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Original Articles

THE CASE OF THE DRUG ADDICT.

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It is not considered good form to begin a paper with an apology but perhaps some excuse should be offered to the society for bringing before it a question which although unanswered has been worn threadbare by numerous discussions.

I am taking this opportunity to submit some suggestions with the hope that the interest of the medical profession in this important health question may be revived.

The Narcotic drug problem should be properly viewed from four angles, it has its medical, social, legislative and judicial viewpoints; and in order to comprehend the question in entirety it is necessary for one to have an intimate knowledge of the composite view.

If we wish to standardize our treatment of these cases it is essential that we have reliable information from authoritative sources, we should admit that valuable work has been done and is still being done to supply data which might serve as working capital, but we must also acknowlede that much of this information is subject to controversy and that therefore we have not been able to recommend any well oranized plan which would satisfactorily care for this type of individuals.

The importance of the question from a medical point of view can not be disputed and it is our duty to inaugurate a program which will be sufficiently elastic to permit of its universal adoption.

An attempt to estimate the extent of drug addiction was made by the U. S. Internal revenue department in 1919 and their published report gives as a conservative estimate that at that time the number of drug addicts in this country exceeded one million; this number may be accepted as our only available reliable figure. Single investigations in the several states apart from the governmental survey, allowing for local exceptions have shown a uniformity in the number of addicts to the per cent. of population.

Prior to the enactment of the Federal Narcotic law, interest in the drug question was sporadic and with difficulty sustained; coincident with the passage of the bill and the resulting publicity a more concerted action developed; states enacted new laws or modified existing ones referring to drug traffic, municipalities became interested and Nation and State wide concern was expressed that this menace to the public if unchecked would lead to impairment of the Nation's health and in other ways contribute to improverishment and economic loss.

Our experience during the years the Harrison law has been in effect has shown defects in the medical construction of the law which would not have existed if the medical profession had manifested the interest in the subject which they now manifest.

There can be no doubt that since the date of their introduction that the consumption of Narcotic drugs has increased, whether this increase is a real increase in the number of drug users or whether it is due to the fact that State and Government vigilance by making it more difficult to procure drugs, is bringing the individual drug user into greater prominence, is still a disputed question. My personal opinion is that the reported increase is not general and is more apparent than real. A considerable per cent. of the number of drug victims are migratory, flocking to the locality where the drug is prevalent, the enforcement of the drug laws in different localities and the emmigration of the drug user is responsible to a great extent for the reported increase of drug addiction in definite geographical areas.

The dope fiend" as the general public understand him is an object of distrust, anti-social and in many cases a criminal. He is credited with having a mental and moral warp prejudicial to any material improvement, and if dis-

*Read at a meeting of the Wayne County Medical Society, January 3, 1921.

ease is admitted by these extremists, the condition is declared to be a disease through the fault of the drug user for which they believe he should be held responsible. The believers in this theory are content with the idea that legislation will control drug usage and advise punishment for disobedience if such laws are violated, a fallacious reasoning as we shall see and one unsupported by facts.

Heretofore, the medical profession has been remiss as we have been content to play as it were a secondary part in the initiation of preventive measures and remedial treatment, allowing ourselves to believe that legislation alone would be a sufficient deterrent. A considerable number of physicians have registered their disapproval of the Federal Narcotic law as it is now exercised, but we must confess that we have taken little part in any constructive program to give medical publicity to this important health question, leaving it in the hands of the law makers and criminologist. In justice to those concerned in framing the laws regulating drug dispensing and drug traffic, we should admit that the Harrison law as originally enacted was a good beginning, a foundation for preventive medical work. I doubt whether those who prepared the law considered it, more than this, we, as physicians, should recognize that legislation will not cure drug addiction, and appreciate that the responsibility of inaugurating and standardizing treatment for narcotism rests upon us. Any method of approach to the solution of the problem must be made with a knowledge of the medical conception of the condition and any method proposed for the alleviation of the situation should be undertaken with a knowledge of the complexities which must be simplified before we can institute a regulation form of care and treatment.

THE DRUG ADDICT.

The make-up and personality of the patient should be the primary consideration, interdependent is the causation complications, and factors which would retard convalesence, this is a fundamental law related to any pathological complex. We must admit that in many instances when called upon to treat these cases, we have disregarded this requisite, we have treated the expression of the weakness, the drug taking, and have failed to administer to the antecedent neuropathic state or to the existing physical disease.

It has often been asked whether drug inebriety can be considered a disease. This has been questioned as the term disease has never been accurately defined, wether we accept the theory that drug addiction once established is due to an antidotal toxic substance in the blood, or whether we regard it as a manifestation of an inherent defect with an unknown pathology is foreign to our present consideration, it is sufficient to recognize drug addiction as the name of a clinical syndrome, requiring an accurate differentiation and a specialized and distinctive treatment directed to the individual case. Differentiation as a diagnostic measure comprises all investigations of the patient to complete the clinical picture of the individual case; it includes a scheme for the complete physical examination with psychometric and other mental tests which will establish the true mental and physical status of the patient, although in a general way the plan of examination corresponds with that for an ordinary morbid state we should remember that we are investigating a distinctive syndrome.

For clinical purposes we may consider that drug addiction is a symptom complex, not a clinical entity, the drug taking episcodical and precipitated by exciting causes of physical or mental origin, given a susceptible subject crises may develop after any marked departure from ordinary routine (mental) or any disturbance of organic nature (physical). By the acceptance of this theory as a working basis we can readily appreciate the vagaries and inconsistencies which are so pronounced in the drug user and we will be able to meet the symptoms with a better understanding as to the underlying causes. If we recognize this description of the drug addict we are prepared to oppose those who would conveniently label the syndrome a "habit" which can be corrected by the patient; there can be no argument as to the habit of mannerism, however, the believers in such a theory are faulty in their reasoning as they fail to recognize the importance of valueing the neurotic state responsible for the habit.

TREATMENT.

When the Harrison drug law was enacted and was put into effect it automatically stopped the supply of drugs to the addict through the ordinary channels, mitigating against this Federal act are the following defects, (a) it did not stop the drug users physiologic need, (b) it did not provide appropriate medical treatment for the removal of the need. The Federal law would have been more effective if proper provision for the care and treatment of the individual case had been made when the original law was drafted. Until recently the several amendments to the law have referred more particularly to enforcement and provisions for abolishing illegal traffic.

Senate Bill No. 2785, introduced in the National Senate, August 15, 1919, from the legislative side is a commendable effort in the right direction the text of the bill which briefly expressed, is to provide aid from the United States for the several states in prevention and control of drug addiction and the care and treatment of drug addicts, and for other purposes is commendable and the bill may be considered as a public health measure and worthy of the support of the medical profession. I am informed that the bill was reported out by the committee on public health on October 1, 1919. With the recommendation that the bill be passed with certain amendments. The bill at this writing is on the Senate calendar.

Legislation, however, is not a therapeutic measure and should not be considered a substitute for medical treatment, however constructive legislation may be, it will accomplish but little without the co-operation of the medical profession. We should meet the proposition squarely, acknowledging it to be our duty to establish a program sufficiently comprehensive to satisfactorily care for all forms of drug addiction.

Before discussing the medical treatment per se I will at the risk of repetition, refer again to the patient, as much of our ill success in these cases is attributable to our failure to recognize the personality of our medical client. The points I wish to emphasize are these, that when we are treating narcotism we are treating three conditions, viz (1) the drug usage, which may be considered the mannerism of the malady and (2) the neuropathy or psychopathy of the individual, the underlying cause responsible for the condition, and (3) complicating physical disease.

Habitual narcotism is an expression of a defect which is in-born, never acquired. This defect as it relates to the drug taking is a lowered resistance to the influence of drugs, just as the bodily system of some persons offers lowered resistance which is inherited to the bacillus tuberculosis. Another analogy is seen in the idiosyncrasies which some persons manifest to drugs which are used for medical effects. Like other psycho neurotics for the drug user (habitual) is a psycho neurotic we find when we make our analysis a multiplicity of nervous and mental symptoms which antedate the narcotism, the symptoms due to the use of the drug, and the consequent intoxication is merely an expression of the defect, the result of the inefficiency of the psycho neurotic. In order to combat this double syndrome which we call drug addiction, we must primarily appreciate the personality of the patient, eventually directing our treatment (1) to the existing defect, (2) to the habit, viz., drug using. The group of symptoms which we call narcotism does not differ materially from the clinical picture of many of the neuroses and psycho-neuroses, in both instances we have well defined nervous instability and engrafted on this fertile soil we have mannerisms and habits which are manifested in a mild or exaggerated form.

The failure to recognize this underlying cause in its formative or incipient stage, and institute appropriate preventive and curative measures, is in a degree responsible for a considerable number of drug addicts who eventually become social outcasts. Recognizing that the habitual drug user is pathologic, we should approach him not with the idea that drastic measures will help him, but with an understanding that a well organized method directed to his individual case is indicated.

Such work is both preventive and remedial and may be considered medico-social work of the greatest importance.

Appreciating the truism viz., that morphinism is really a complex viz. a neurotic inefficiency plus one of its expressions, drug taking we are prepared to accept the assertion that there can be no general or specific cure for drug addiction.

As is well known, the customary method of treatment relates to the technic of the withdrawal of the drug and a definite method is selected for this purpose; such a practice is commendatory as the initial step is the control of the drug intake, unfortunately, in many cases the personality of the patient is ignored and psycho-therapeutic treatment is neglected; this mental treatment of the patient is essential if we aim to secure the maximum success, one other factor not infrequently overlooked by the physician is the necessity for individualization and a realization that "group method of handling these individuals is wrong in principle and practice. "Every case a law unto itself," should be our slogan, the determination of the average daily amount of drug required, the selection of the method for the withdrawal of the drug, the election of a hospital for the patient, and lastly the treatment during convalescence, including psycho-therapeutic measures depends on the practice of this therapeutic principle.

The modern treatment of drug inebriety consists, (1) in getting the patient interested in himself, and (2) in encouraging him to sustain this self interest in his defect. The successful treatment of drug addiction has a three-fold principle, a physiological life, abstention from

drugs, and the institution of moral and educational measures.

Morphinism and other forms of drug habituation have mental and physical syndromes, if a patient is free from organic disease, recovery from the physical symptoms incidental to the drug addiction is a matter of comparatively short time. However, the mental training required to prevent a relapse requires a certain mentality and a longer period of time.

The number of drug addicts in the United States in 1919, taking the estimated population of 106 million was 1,338,000. This figure is again given in order to establish (a) a practical reason for the promotion of a definite plan for the treatment of drug addiction, (b) to emphasize the fact that an individual who by reason of mental or physical disease acquiring the use of narcotics is entitled to all benefits possible from medical skill and practice. My personal knowledge and analysis of 5,000 cases of drug addiction during the past ten years has shown that over 59 per cent. of these patients exhibited mental, nervous or physical defects, which antedated the use of the drugs; certainly a strong argument for the proper handling of these cases.

Realizing the need for such work we should demand that in every locality that there be established facilities for laboratory work, investigation, and treatment, namely (1) a hospital for necessary laboratory work and treatment (2) a state-wide out-patient department providing for (a) medical and social work, (b) facilities for educational purposes, (c) proper extension of the rehabilitation work inaugurated at the hospital.

Thus far the suggestions offered for treatment refer more distinctively to the social users of drugs, of which there are approximately 70 per cent. although we might dismiss the remaining 30 per cent. of the number of drug users as belonging to the criminal class, and related to criminology, as physicians we are obligated to prescribe for them a method of treatment consistent with our findings; defective delinquents cannot be cared for or treated successfully in a general hospital or by methods designed for the treatment of the frank, non-criminal case. Such cases should be cared for in an institution with adequate equipment and appropriate disciplinary control. My personal investigation of local jails and houses of correction justifies me in making the statement that with few exceptions drug addicts receive but little if any medical treatment for drug addiction, while awaiting trial or undergoing sentence.

Any program to better conditions and to lessen the cost to the state of drug addiction and of crimes related to it, must consider both prevention and cure. The prevention of drug taking has its source not only in the diminished production of opium and its regulated sale and distribution, but quite as much in the construction of healthy bodies, well balanced minds, high moral standards, and strong minded wills over which drugs can have no power. Until these ideal constructive measures can be brought about certain types of men and women whose minds and bodies are impoverished will find some means of intoxication. However, certain measures for the cure or amelioration of drug inebriety are practical immediately, to attain this end it is necessary to discover the curable case and give him specialized treatment, and detect the criminal drug user in order that he may be given the custodial care which his case demands.

Recognizing that habitual drug using is pathologic, we should approach the problem not with the idea that drastic measures or legislation can check it, but rather with the understanding that an organized and well conducted method is alone appropriate.

The measures appropriate for the proper handling of the habitual drug case are as follows:

1. In every community there should be a centralized bureau, preferably the state board of health; the department thus created, should have complete control of the drug situation viz the prescribing and distribution of narcotic drugs, and the election of institutional care if such should be expedient. The state board of health acting in this capacity should in every way co-operate with the Federal Government.

2. This recommendation does not in any way prohibit the individual right of the physician to prescribe; such prescriptions should be filled by druggists or agents authorized by the controlling board, the original prescription or a copy thereof becoming automatically a permanent record of said board.

3. Every state should set aside a hospital area or areas, properly supervised and equipped for the care and treatment of cases of narcotism. These hospitals should furnish not only the distinctive mental and physical treatment which the drug case is entitled to, but should provide for and maintain a well organized medical and sociological out-patient staff, which would not only extend the educational treatment begun at the hospital, but which would have as an important function, state wide spread preventive and educational work.

Such hospitals and the related state wide clinics should be supervised and controlled by physicians as directed by the controlling bureau.

SUMMARY.

1. The habitual drug user is a neurotic, and the fundamental traits of this condition are dominant factors in his personality or make-up; this inefficiency, a constitutional inferiority, antedates the drug taking which may be rightly considered an expression or mannerism of the defect.

2. Approximately 70 per cent of all cases of drug addiction are frank cases purely antisocial, without a criminal history; the remaining 30 per cent. are irresponsible and vicious, and may properly be classed as criminal recidivists; manifestly these two permissable groups require different methods of treatment.

3. For clinical purposes two groups of drug addicts are admissible, the primary or larger group comprising 70 per cent. exhibit no criminal tendencies, the smaller or secondary group embracing the remaining 30 per cent. are inherently criminal and are not responsive to treatment. The treatment of the two groups should be consistent with the findings in the individual case; generally speaking the non-criminal group requires a minimum hospital residence, with maximum psycho-therapeutic treatment, while the criminal drug user demands more prolonged institutional care and more exacting discipline.

4. The treatment of narcotism consists of two factors: (a) the withdrawal of the drug; (b) the institution of psycho-therapeutic measures, directed to the individual case.

5. While the present Federal narcotic law is in force, it is recommended that the dispensing of all narcotics as described by the Harrison law, be controlled and authorized by a central bureau, preferably the State Board of Health, and that such administrative agency co-operate in every particular with the medical profession and the Federal Government.

6. The problem is a public health question of great importance and pending the enactment of an international law regulating the production and disposition of opium and its derivities the question of individual application of any narcotic law should be relegated to the physician who must necessarily conform to any existing law regulating the dispensing of narcotics.

7. The medical profession, when assuming such responsibilities must recognize the importance of the task and try to secure legislation which will not handicap the physician in performing his duty to his patient and to the public in general.

A SECOND PUBLICATION ON ULTRA VIOLET RAY THERAPY WITH CASE HISTORIES.

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In September of 1920, the author published a short paper entitled "Ultra Violet Ray Therapy" in which he very briefly reviewed the history and the opinion of various authors concerning light therapy. His opinions and deductions were based on 2,275 treatments given. Since then he has given more than 1,500 treatments.

In this paper he wishes to present a few case histories.

Mrs. M.: Age 65 years, married, has four healthy adult children. Has suffered for past ten years with chronic rheumatism, all finger joints are moderately deformed, wrists, elbows and shoulder joints have been involved, at present not envolved. Left knee is swollen, thickened and has lost 75 per cent. of motion, is unable to bend over. Patient has moderately large, chronically infected tonsils, also a chronic myocarditis with a mitral regurgitation. Patient has been under continuous care for past 10 years, using stock and autogenous vaccines, diet, many different drugs internally. Hydrotherapy, etc., high frequency, D'Arsonval currents, etc., etc.

After ten weeks of ultra violet ray treatment, patient is in much better condition than at any previous time during the past ten years. She can bend better, clean cupboards, etc., and is practically free from pain.

Treatment: Tonsils and sinuses treated with Kromayer lamp, applying the rays directly on the tonsils and deep into the nostrils. The entire body was exposed to the Alpine sun lamp and Radio-Vitant lamps. In all, 21 treatments were given.

During most of the treatment no medicine was given.

Case 2. Mrs. B.: Age 42, married, one child. Two miscarriages due to hyperthyroidism. Wassermann negative, diagnosis of Addison's disease made 18 months ago in Washington, D. C., Hay fever for 20 years.

March 19, 1920: Patient starts treatment for severe sacroiliac strain accompanied by neutritis. She also presents lichen planus on both wrists, forearms, on neck and both legs. The severe itching prevents sleep. The left maxillary and right frontal sinuses are tender on pressure and there is slight soreness in both tonsils.

A slight leucorrhoea is present, menstruation

accentuates back pain and sciatica, and is accompanied by nervous headaches which necessitate her lying down.

Treatment: Canvas web compression belt to relieve back strain, broad, sensible shoes, back pads placed in chair and bed to support curve of back; 2 cups of hot water morning and night with one cake of Fleischmann's yeast morning and night to keep the intestinal tract clean. Alpine and heat lamp over back, electrical vibration of back twice a week.

May 14, 1920: Pain in back when tight corset is not worn, moderate general improvement, less nervous.

June 15, 1920: Has had two treatments with Kromayer lamp which completely relieved rose fever, and sinuses are free from pain. Has had several general body treatments with Alpine lamp which has cured the lichen planus. General health is much better, sacro-iliac pain and sciatic neuritis cured. Stops treatment.

August 31, 1920: Mild attack of hay fever appears. Great improvement over former years. General health is good; a patch of lichen planus has reappeared on wrist. Symptoms all relieved with a few general body Alpine and local Kromayer treatments. Menstrual periods now are normal, no headache.

October 11, 1920: Left sacro-iliac pain and left sciatic neuritis for past week. An additional 4 inch belt applied superior to present belt. General health excellent. General Alpine treatments to October 26th relieves all symptoms.

January 6th, 1921: Lichen planus has reappeared on wrist and a dollar sized patch is present at left anterior axillary line. She feels nervous. No more backache or sciatic neuritis, menstrual periods are "perfect," no sinus trouble. General Alpine and Kromayer locally to patches of lichen planus relieve itching and lessen nervousness. Rapid abatement of nervousness and complete cleaning up of lichen planus.

Case 3. May 22, 1920: Mrs. C., age 33, married, one child, no miscarriages.

Dr. Evans reports that stereoscopic X-ray plates were made showing the lower lumbar and sacro-iliac region. There is a sacro-iliac asymmetry without evidence of sacro-iliac irritation. There are shadows of lime density on the right side opposite the fourth and fifth lumbar segments, probably calcified peritoneal glands. There is lumbo sacral pathology, there being increased density about the articulation of the fifth lumbar with the sacrum. The angles of the fifth show bony overgrowth, especially at the upper angle. Symmetrical facets between the fourth and fifth segments.

Rectal examination negative. Vaginal examination reveals large tear of the cervix, uterus and adnexa normal. A constant leucorrhoeic discharge which produces a pruitis with intense itching.

Heart, lungs, abdomen negative. Tonsils were removed "20 years ago." Has had six attacks of tonsilitis in the past 4 years.

General examination reveals an exceptionally healthy well built Scotch woman 5 feet 6 inches tall, weight 165 pounds. There apparently is no asymmetry. Pain in lower sacro-iliac region is so severe that patient has great difficulty in disrobing. In having her lie down on operating table, a step ladder was needed, with one person compressing sacro-iliac region while a second person swung the lower extremities on the table. No attempt was made to examine mobility of spine or hips on account of pain.

The entire body was intensely rayed with radiant lamp and the Alpine sun lamp. The back was thoroughly vibrated and a counter irritant ointment worked into back. A prolonged vaginal and rectal treatment with Kromayer lamp given, genitalia also rayed which immediately stopped the itching from the pruitis.

All pain was removed during the first treatment. On resuming her feet a light sacro-iliac belt was applied over her corset which was laced correctly. Proper supporting pads for chair and bed were ordered and patient told how to protect her back. Ten glasses of hot water per day and two cakes of yeast prescribed as medicine.

May 24, 1920: Patient takes second treatment. A marvelous improvement in her opinion. Leucorrhoea practically well, very little pain.

Treatments on May 25th and 26th, 1920; Pain entirely relieved and leucorrhoea stopped. Patient attends a Scotch picnic.

July 17, 1920: Free from pain until yesterday. She lifted a wash tub and strained her back. A fifth treatment was given which relieved all pain.

A letter from the patient several months later states that she remained well.

Case 4. October 18, 1920: Mr. P., age 50, carpenter. Colles fracture of right radius.

Brachial plexus blocked with one-half of 1 per cent. of novocaine, injecting the nerves above the clavicle. Local anesthesia circuminjected at point of fracture. Anesthesia perfect. Patient and splints taken to Dr. Evans' office where perfect reduction in both planes were made under fluoroscope. Splints were applied, plates taken. Dr. Evans' report: "We note a fracture through the lower end of the radius, with satisfactory alignment of the fragments in both planes."

After-treatment: During following 4 weeks patient had 17 office treatments. There was no soreness or pain after first 48 hours. At each treatment splints were removed, patient baked with Radio-Vitant and Alpine lamps, electrical vibration, manual manipulation and high frequency electricity used. On the 15th day patient strapped a razor and shaved self with the right hand, i. e., the broken wrist hand. At the end of four weeks he returned to work. He wears a leather wristlet. Eight weeks following injury he called at the office, stating that he was working full time, but that pounding spikes jarred his wrist. He believes that 100 per cent. function will return.

Case 5. Mr. K., age 38, married. In July, 1920, 3 left upper molar teeth were extracted. Necrosis of that portion of the alveolar process and superior maxilla ensued, accompanied by pain, bloody discharge, temperature, loss of weight, appetite and strength.

October 10, 1920: Patient begins ultra violet ray treatments. X-ray reveals osteomyelitis. Patient's jaw given 10 minutes intraoral Kromayer lamp application. Entire body treated with Alpine and Radio-Vitant lamps. Normal saline mouth wash, pyorrhoea alveolaris vaccine, 2 cakes of yeast per day and 8 cups of hot water per day prescribed.

The first treatment greatly relieved pain and loosened up a necrotic piece of bone which the patient worked out with his tongue.

October 13, 1920: A more intensive treatment given. Less pain, another piece of necrotic bone removed, marked improvement in general health.

October 16, 1920: Third treatment more intensive, a third piece of bone extended.

October 25, 1920: Fourth and last treatment. The last piece of necrotic jaw bone came away that night and symptoms ceased.

December 30, 1920: Patient re-examined, no evidence of jaw infection, gums healed, no pain on percussion, general health normal.

Case 5. Mr. W.: Age 30, single. On November 19, 1920, had pain in lumbosacral region due to gonorrhoeal prostatitis following infection of April 1st, 1920. Polyuria, dysuria, fever, "sick all the time." Patient says, "My morale is low."

Treatment: Radiation of entire body with Alpine and Radio-Vitant lights, Kromayer light intra-rectally to prostate and intra-urethrally to posterior urethra. To drink large quantities of water. No other medication.

Treated on November 19, 22, 26, December 3, 10, 17 and 24th. Patient then stated that he was entirely cured.

Case 6. September 8, 1920: Mrs. W., age 38. Infected ingrown toe-nail, right great toe, 3 months duration, unable to wear shoe. Cured in one treatment.

Treatment: Prolonged radiation of leg and foot with Alpine and Radio-Vitant lamps. Great toe treated with Kromayer lamp. Nerves of toe blocked with one-half of 1 per cent. novocaine solution and ingrown portion of nail and matrix excised. Wounds treated with Kromayer lamp. Wounds entirely cured in 4 days. Remains cured.

Case 7. October 20, 1920: Mr. W., age 63. Hit by an automobile, received 13 abrasions on right hand, 5 abrasions and cuts on left hand. Abrasions on chin, tip and bridge of nose. Abrasion 2 inches in diameter on forehead with 1¼ inch cut to skull. Abrasions of scalp. Abrasions and deep bruise of left shoulder and deep upper thorax, accompanied by severe pain on breathing.

Treatment: Entire upper body baked with Alpine and Radio-Vitant lamps. All wounds treated with Kromayer lamp, sterile dressings. High frequency and D'Arsonval current to aid in relieving pain and agitation.

Same treatment on October 21, 22, 23, 25 and 26th. All wounds entirely healed without inflammation, infection or pain, in spite of the street dirt ground into the wounds.

Case 8. November 24, 1920: Mr. S., age 34, height 5 feet 11 inches, weight 255 pounds. Patient was in Dodge sedan which was entirely wrecked by hitting a tree and turning over, down an embankment. The entire body is bruised. Left hip, thigh and upper leg is inky black, lower leg purple. There are seven lacerations thru skin and fat, 1 to 2 inches long, 4 area's where skin is brushed off. Right hip and thigh purple. Tip of right elbow has skin and subcutaneous tissues "brushed off" as cleanly as if excised. Both wrist and hands very lame. Patient unable to undress himself for treatment.

Treatment: Entire body thoroughly baked with Alpine and Radio-Vitant lamps, D'Arsonval and high frequency current applied.

After ninety minutes of treatment patient felt much better, dressed himself alone, putting on shoes, overcoat, etc.

November 26, 1920: Patient is greatly improved, all wounds are clean and will heal without infection. Inky blackness of thigh not so marked. Prolonged general treatment given, Kromayer lamp being used on the wounds.

November 29, 1920: Very marked improvement from each prolonged treatment. Wounds healing nicely.

December 13, 1920: Fourth and last treatment. All wounds solidly healed. Left thigh slightly discolored. Slight stiffness remains. This 255 pound man continued at work as vice-present of an automobile concern throughout treatment.

Case 9. February 6, 1920: Mr. P., age 36, married, begins treatment. Operation for appendicitis on January 3, 1920. The appendicial soreness is gone, belching of gas more frequent and severe. Lumbo-sacral iliac for past 18 months, aggravated by operation. Patient is mentally depressed. Wife and two children depend on him. He is in debt and sick.

Treatment: Radiation of entire body with Alpine lamp, canvas web sacro-iliac belt applied over a straight front corset, proper supporting pads for spine when sitting or lying, taught correct posture, proper diet prescribed, constipation relived by drinking 8 cups of hot water each day.

Patient had 15 office treatments, ending on March 19, 1920. He then was entirely free from any symptoms due to back strain, his general health was greatly improved, indigestion better, bowels more regular. He resumed work feeling capable to provide for family and self.

Case 10. November 20, 1920: Mr. C., age 54, height 5 feet 6 inches, weight 235 pounds. Patient is a very rotund retired business man who has lived well.

Dr. Evans' X-ray report: "Plates were made of both feet laterally with the central rays directed thru the os calcis. There is a little extra density at the attachment of the plantar fascia to the os calcis on the right side. We believe that this is a beginning bony spur formation."

For 2 years patient has been unable to obtain relief from pain under the center of the heels. Standing or walking aggravates the pain. Spends considerable time sitting down with feet elevated. This position helped, as it drained the blood from the heels.

Treatment consists of intense radiation to soles of the feet, heels especially, twice a week with

the Kromayer lamp. This relieves pain and greatly benefits the condition.

Case 11. Mr. S., age 30: On November 3, 1920, received a second degree burn of right arm from thumb-tip to elbow, due to gasoline and oil explosion. Large blisters present.

Patient was treated on November 4, 5, 6, 8 and 10th by prolonged exposures to Alpine and Radio-Vitant lamps. Burning and pain immediately removed. Burn dressed with paraffine gauze and a bland ointment. Burn completely healed on November 10, 1920.

This method of treating the above cases seems entirely logical. We are all familiar with the marvelous healing and growing power of sunlight. Adding ultra violet rays intensifies this action. Ultra-violet light penetrates the body like the x-rays. In doing so it is transformed and stimulates the action of the body cells.

Most diseased conditions are associated with a disturbance of the circulation; congestion in one part, anaemia in another. This treatment relieves congestion of internal organs, producing a flushing of the skin and muscles due to dilitation of the blood and lymph vessels. It aids elimination by directly stimulating the sweat glands and reflexly stimulating the spinal centers. Internal congestion is relieved, allowing the liver, kidneys, etc., to carry on their work. Toxic substances in the blood are broken down and the heart and respiratory action is increased.

A CASE OF ALEUKEMIC LEUKEMIA CLINCIALLY RESEMBLING VON JAKSCH'S ANEMIA.*

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In 1889 and 1890, Von Jaksch (1) reported a series of cases of anemia occurring in infants and young children, characterized by splenomegaly, enlargement of the liver, and a blood picture of a very severe anemia with marked increase in the white blood cells and nucleated erythrocytes. Since the time of his publications numerous papers have been written concerning this condition. Von Jaksch believed it to be a special disease entity, peculiar to infants and young children and gave to this condition the name Anemia Infantum Pseudoleukemia. There has been much controversy regarding the etiology and classification of this disease. The view of Dunn (2) is perhaps the best expression of the present opinion concerning this point. He believes that if the term Von Jacksch's anemia be confined to cases of anemia of unknown etiology with full recognition of the fact that exactly the same disease picture can be produced by many known causes, the question of the separate identity of the disease loses its interest and importance. In other words, Von Jaksch's anemia is not a disease, but a syndrome embracing both anemias of known and unknown etiology.

From time to time in the literature cases have been reported of leukemia (demonstrated at necropsy) which during life gave a picture similar to Von Jaksch's anemia. In fact one of Von Jaksch's original cases turned out to be a leukemia at autopsy. Lately, Gordon Ward (3) of London has discussed this point again. He quotes Martinelli (4), an Italian pediatrician, who believes that cases of Von Jaksch's anemia are potentially leukemic. He considers that the preleukemic condition arises from the effect of one of several factors acting on an inherently defective organism, and especially on those of thymo-lymphatic constitution.

Forbes (5) has reported two cases of anemia in children aged 13 and 18 months respectively which clinically correspond to Von Jaksch's anemia. Both children died of bronchopneumonia and at autoposy a picture somewhat resembling leukemia was found. Forbes questions whether these cases should be called Von Jaksch's anemia in which no positive evidence of leukemia is found at autopsy.

Ward (6) writing on Von Jaksch's anemia, states his views as follows: He believes the term pseudo-leukemia infectiva to be essentially correct. The disease occurs between 6 months and 2 years. The onset is gradual and often associated with rickets. The chief symptoms are splenomegaly, emaciation, and anemia. The blood shows a diminution in red cells and hemoglobin. There is a marked increase in nucleated red cells, also an increase in white cells, especially myelocytes and myeloblasts. The disease resists specific treatment, but may be recovered from if infections are removed, otherwise it progresses fatally with death from pneumonia or inanition. There is no tendency to hemorrhage, jaundice or cirrhosis of the liver and he finds that the fragility of the red blood cells is normal.

Ward states that the pathological picture is identical in its nature and its distribution with the lesions of myelogenous leukemia as we see that disease in the adult, but not identical in its

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extent. Foci of abnormal, actively forming red and white cells are found in the liver, spleen and glands. The disease is differentiated from adult leukemia by a different clinical picture and by the fact that the adult forms of leukemia occur in childhood.

In this connection I wish to report a case which during life resembled Von Jaksch's anemia very closely, but at necropsy a picture of leukemia was found.

Charles B., aged 20 months, was admitted to the Pediatric department of the University Hospital, Sept. 21, 1920.

Chief Complaint. "Yellow color" (duration 4 months).

Family History. Child born at the maternity ward of this Hospital. Both mother and child had negative Wassermann reactions at this time.

Birth History. Normal.

Feeding History. Has been fed on cow's milk dilutions up to 1 year. Since then has had general diet. Details unknown except that appetite was always good and child has gained weight.

Past Illnesses. None.

Present Illness. About 4 months ago, June, 1920, the parents noticed that the boy's skin was becoming "yellow." The peculiar color of the skin has been gradually growing more intense. The lips have been getting paler, also the child has been gradually growing weaker and more listless. About one week before admission, the child began to have a fever, height unknown. This has persisted up to the present. Enlargement and tenderness of the abdomen were first noticed at this time. He has been losing weight for at least six weeks. The stools have always been normal and yellowish brown in color. The urine has been a very dark brown since the onset of the illness. There have been no hemorrhages nor any purpuric spots on the skin.

Physical Examination. The patient is a male white child, fairly well developed and nourished. The temperature is 101.4 F, pulse 110, and respirations 25. The child is quite restless and irritable, but is extremely weak and his cry is very feeble. He can not even sit up alone.

Head—Normal size and shape, anterior fontanelle is closed, no prominent bosses or craniotabes.

Nose—Normal, no discharge.

Eyes—Pupils react to light—conjunctivae very pale, sclerae are bluish white in color.

Ears—Tympanic membranes normal.

Mouth—Teeth in good condition, mucous membranes are very pale, throat pale, tonsils not inflamed.

Neck—No rigidity or retraction, no venous pulsations, thyroid normal.

Thorax—Symmetrical, no rosary or Harrison's groove.

Lungs—Clear throughout.

Heart—Apex in the 4th intercostal space ½ cm. to the left of the nipple line. Right border is 1 cm. to right of the sternum. There is a soft blowing systolic murmur, heard over the precordium, but loudest over the pulmonary area. P2 is not accentuated.

Abdomen—Is somewhat full with a prominence in the left upper quadrant. There is no enlargement of the superficial veins. No hernia. The spleen is much enlarged, filling the left upper quadrant and extending 12 cm. below the costal margin in the nipple line. The surface of the spleen is smooth and the splenic tumor is quite hard and firm. The liver is also enlarged and felt 3 cm. below the costal margin in the right nipple line. It also feels hard and smooth. No tenderness found anywhere over the abdomen on palpation. No evidence of any fluid.

Genitals—Negative.

Extremities—Normal in size and shape, no spasm or paralysis. The muscles are quite weak and flabby.

Reflexes—No abnormalities noted.

Glands—No adenopathy.

Skin—The color is quite striking, being of the pale lemon yellow seen in the pernicious anemia of adults. The panniculus is abundant. No hemorrhages or petechiae. There is moderate loss of elasticity of the skin, suggesting a chronic loss in weight.

Laboratory Findings.

Wassermann reaction negative.

Von Pirquet test negative.

Stools negative for ova or parasites.

Urine (only one examination), dark brown in color, negative for albumin, sugar, bile and blood. Microscopic examination negative.

Blood (Sept. 21, 1920.)

Red blood cells 1,560,000.

White blood cells 29,300

Hemoglobin 15 per cent. (Miescher).

The stained smear showed marked polychromatophilia and poikilocytosis.

Differential Count.

Polymorphonuclear neutrophiles	59.3%
Polymorphonuclear basophiles	1.5%
Polymorphonuclear eosinophiles	.5%
Small lymphocytes (small type)	24 %
(large type)	6 %
Large lymphocytes	3.3%
Myelocytes	5.3%

Nucleated Reds.

In counting 200 white cells, 108 nucleated reds were seen of which there were 74 normoblasts, 22 megaloblasts and 16 erythroblasts.

Blood examinations during the next two days were practically the same.

Further Notes. The day after admission the temperature rose to 102 and the respirations to 50. Examination of the lungs showed a few crackling rales at the left base and the breath sounds were slightly higher in pitch. A diagnosis of beginning pneumonia was made.

The following day (Sept. 23,) the condition of the patient became much worse. 80 c. c. of blood was taken from the father and injected into the juglar vein of the child. At this time the pulse was 160 and respirations were 120. A slight improvement was noticed immediately after the transfusion, but the condition soon became worse.

The child became stuporous and died at 5 p. m., Sept 23rd.

Clinical Diagnosis:

(1) Von Jaksch's anemia.
(2) Early Broncho-pneumonia.

Necropsy. (2 hours after death).

Abstracted from the protocol of the Department of Pathology.

Gross Findings. Body is that of a fairly well nourished and developed white child. The paniculus is abundant. No anomalies or deformities. There is a small amount of yellowish fluid in the peritoneal cavity. The spleen is very large, about 5 times the normal in size. It is quite hard and firm, and on section shows an increase in stroma with hypoplastic follicles. The liver is enlarged and on section shows golden yellow pigment at the periphery of the lobules (bile pigment). There is marked hyperplasia of the mesenteric lymph nodes. The bone marrow is hyperplastic. The lungs show congestion and edema. The heart is soft and flabby, the valves are negative. The thymus is normal. Kidneys are negative.

Microscopic Findings:

Heart—Simple atropy, leukemic clots.

Lungs—Marked congestion, edema-hemorrhage, early pneumonia, many of the blood vessels show a leukemic picture.

Thymus—Slight lymphoid hyperplasia.

Spleen—Marked congestion, increase of nucleated forms in the circulating blood, germcenters hypoplastic, many of them exhausted.

Adrenals—Hypoplastic.

Liver—Chronic passive congestion (nutmeg liver), fatty degeneration, atrophy and necrosis of center of lobule. Mononuclear infiltrations of the islands of Glisson, the picture of leukemic infiltration-icterus.

Bone Marrow—Leukemic bone marrow.

Pathological Diagnosis—

1. Early Myelo-lymphatic leukemia.
2. Broncho-pneumonia.
3. Hypoplasia of the adrenals.
4. Icterus.

COMMENT.

This case represents one of the anemias which are clinically grouped under the name of Von Jaksch's anemia. There was no evidence of rickets, nor of syphilis or tuberculosis. It is probably one of the rare forms of leukemia seen in an aleukemic stage, a condition, which would be impossible to diagnose during life unless observed over a long period of time. The case reported here bears a close resemblance to Von Jaksch's first case described in 1889, however, most of the cases called Von Jaksch's anemia show no true leukemic changes at autopsy. I believe that this case would best be described under the title of an aleukemic leukemia presenting Von Jaksch's syndrome and think it would be better to consider such cases as these, as a separate group, one of the types of anemia of unknown etiology, occurring in infants and young children which progresses steadily to a fatal termination in spite of any treatment.

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I wish to thank Dr. D. M. Cowie for the privilege of reporting this case from his service.

MODERN CARE OF THE OBSTETRICAL PATIENT.

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Recently in reading an article by C. H. Davis (1) entitled "Maternal Mortality," I was impressed by the fact that with all the progress made in obstetrics in the past twenty years, the maternal mortality remains far too great. According to statistics quoted by Davis, childbirth is the second greatest cause of death among women between the ages of fifteen to forty-five years. In this same article, statistics taken from the government report and compiled by Grace L. Meigs (2) show that comparing the United States with fifteen foreign countries, Switzerland and Spain have a higher maternal mortality and that our country stands fourteenth on the list. The rate given for the United States is 14.9 per hundred thousand population. A paragraph taken from Grace L. Meig's report is startling, and should be a challenge to every physician in our country who practices obstetrics. She says: "according to the evidence available, these death rates are apparently not decreasing. During the twenty-three years ending in 1913, in this country no definite decrease in the death rate from the diseases caused by pregnancy and confinement can be demonstrated; nor can any decrease in the death rate from puerperal septicemia be shown."

Physicians who in their daily practice, meet women and children cannot fail to see the never ending train of humans, damaged by a physiologic process, namely birth. The mothers come with lacerations, relaxed vaginal outlets, retroversions, prolapsed uteri, cystoceles, rectoceles, adherent pelvic organs, chronic infections, fistulae, urinary and fecal incontinence, paralyses, ilio-sacral disease, traumatic neuritis, mental and nervous disorders directly traceable to

child birth. The children come with fractures, cerebral hemorrhages, birth paralyses, mental inferiority and epilepsy. The responsibility for all of these conditions cannot justly be placed upon the physician, but the problem of reducing this high maternal mortality and of decreasing the number of damaged mothers and children, is ours.

It is not the object of this paper to criticize the physician, for no praise is adequate, no reward too great for the physician who gives careful, conscientious service to the pregnant woman. Rather would I suggest a plan whereby our problem may be made easier and the results better.

The care of the obstretrical patient should begin as early in pregnancy as the first or second month. At this time a history should be taken to learn of any damage done to the patient by sickness; and the course of former pregnancies. A careful pelvic examination should be made to ascertain the size and shape of the bony pelvis; to correct misplacements and detect pelvis pathology. Many patients who habitually abort will carry a child to full term if a retroverted pregnant uterus is put in a normal position and kept there by the use of the pessary and knee chest exercise; and the reflex type of nausea and vomiting is often cured by this same procedure.

Knowing the tendency of pregnancy to light up an old pulmonary process or a kidney lesion, to aggravate a cardiac lesion by the increased work and to tax all of the organs of digestion and elimination, a thorough physical examination is necessary. A radical change in diet may be necessary, an urgent indication for terminating the pregnancy may be found, indeed a complete change in the manner of living may be advisable. An often neglected but very fruitful source of satisfaction to the patient and physician is early detection and intensive treatment of gonorrhea and syphilis in the pregnant woman. Both of these diseases may be treated thoroughly during gestation without injury to the child. Local treatments with silver preparations and warm vaginal douches of potassium permanganate or other suitable agents will often prevent any gonorrheal complications. Intravenous and cutaneous treatments directed against syphilis will often prevent abortions, bring a healthy appearing child into the world and cause a marked general improvement in the mother. At birth a little blood taken from the cord will give a good idea of the child's condition and the mother and child may continue treatments during the puerperium and on to recovery.

No antepartum examination is complete without a blood-pressure reading and a careful urinalysis. The blood pressure which is normally low during pregnancy, rises rapidly with a threatened nephritic or eclamptic condition. These observations, with repeated urinary examinations, should prevent many patients reaching a most dangerous state of toxemia. Usually urine examinations and blood pressure observations are made each month up to the seventh month, then oftener. I believe that they should be made at shorter intervals for eclampsia may be so fulminating in its outset that only a few days may elapse between the earliest signs and symptoms and the ofttimes fatal convulsive state.

Most of us have been taught and from observation have come to believe that nausea and vomiting must accompany the early months of pregnancy. We must now alter our viewpoint and interpret these symptoms and signs as manifestations of altered metabolism, dietic error, failure of proper elimination, lesions in or about the generative tract, and manifestations of an unstable nervous system. So important is the modern view of this phase of obstretics that I will briefly state its present status. All patients suffering from excessive vomiting of pregnancy pass through a state where their symptoms are not marked. It is at this time, early in pregnancy, that the physician can do his best work. Cases of hyperemesis gravidarum may be divided into three types, namely the neurotic, the reflex and the toxic types. The group classed as neurotic cases, embraces many women who have inherited unstable nervous systems and those women who do not desire offsprings, but find themselves pregnant. Often sound advice by the physician or some unusual treatment is sufficient to work a cure. Many of these patients need treatment directed toward the nervous system, for example, isolation, suggestion, nerve sedatives or similar measures. The reflex type if found by pelvic and abdominal examination. I have already mentioned those patients with a retroverted uterus and the splendid results attending the correction of this displacement. The removal of ovarian cysts and chronic appendices is sometimes necessary to stop the vomiting. The local treatment of a cystitis, urethritis or endocervitis will often accomplish the desired results. By far the most important group is the toxic type. The majority of patients fall into this group. Often if seen early and properly treated they respond quickly, but when neglected they soon pass into an extremely trying and dangerous state. Many

of the neurotic and reflex types pass over into this group when untreated. All modern views of this subject and all of the results of research work show that dietetic errors and improper elimination in the pregnant woman soon lead to vomiting, then on to a slight degree of starvation, then to a state of acidosis, on to dehydration and finally serious and often fatal visceral changes. In order to stop this dangerous progression it is necessary to see the patient before marked starvation with the accompanying acidosis is well developed. Correction of constipation, increasing the liquid intake, decreasing proteids and irritants of the kidneys may be sufficient to relieve the patient, but a diet high in carbohydrates is almost specific for these early cases. Titus, Hoffman and Givens (3) have recently published a paper entitled "The Role of Carbohydrates in the Treatment of Toxemias of Early Pregnancy." They state that frequent small meals and lunches containing much carbohydrate will relieve mild cases of nausea and vomiting. They advise soda crackers before rising, a light breakfast, soda crackers and milk in the middle of the morning, a light lunch without meat or pastry, the dessert being cornstarch or rice pudding or custard. Afternoon tea with arrow root biscuit or bread and butter sandwiches. A light dinner or supper similar to the luncheon, a bowl of bread and milk at bed time and crackers and water to be taken during the night. Severe cases are given, in addition to the diet suggested 8 to 16 ounces of a 10 per cent. glucose and 2 per cent. sodium bicarbonate solution daily by mouth. This may be given in 1 or 2 ounce doses. The seriously toxic patients are given an initial period of rest, gastric lavage, and the introduction of saline cathartic through the stomach tube, the glucose and soda solution is given by mouth and bowel. About one quart being given in 24 hours.

At the time of these early visits to the physician the patient should be informed about diet, elimination, exercise, sexual life and should be directed to report any abnormal symptoms or signs. It is surprising how often patients fail to report slight flowing, severe headaches, slight edema of eyelids and ankles and scanty urinary output unless warned to report them. During the last two months of pregnancy the physician is constantly on guard for signs of complications. Faulty positions of the fetus, placenta perviae, premature separation of the placenta and frequency of the toxemias during this stage make it a particularly critical period.

The obstetrical patient having passed all of the hazards of the gestation period, arrives at the time of labor. Probably the time will never come when all women will be confined in hospitals or institutions for maternity patients, but the sooner those patients showing abnormal conditions are detected and cared for in hospitals the sooner our maternal mortality statistics will fall. Any patient who in former pregnancies or during the course of any pregnancy shows marked abnormalities should be a hospital patient. Every obstetrical case at labor is potentially a surgical case and the physician must be able to handle it as such. In the home this is often impossible. Hospital care is better for the mother and child and far more satisfactory to the physician. These facts are hard to impress on multiparous women but the primiparous patient is easily convinced and once confined in a hospital, is rarely satisfied to remain at home at subsequent labors. I often marvel at the kindness of Nature, the good fortune of the mother and child and have only words of praise for the physician, who so often, in rural districts, and under unsanitary surroundings successfully handles a serious obstetrical complication and brings a favorable outcome to both mother and child; but all of us can recall patients who would have done better had they been in a hospital, where asepsis was possible and all modern appliances were available.

Time is too limited to mention all of the improvements and changes that have proven useful in obstretrics but I wish briefly to mention some of these. As an anesthetic during labor, chloroform is losing its popularity and is being replaced by ether. In institutions nitrous oxide during the long trying first stage is a wonderful agent especially for the highly nervous woman. It is practically harmless to both mother and child and certainly relieves the patient at the peak of each pain. It may be used until the head is partly crowned, when a change to ether makes a slow delivery of the head possible.

During labor rectal examinations may be made frequently and the progress of cervical dilatation and descent easily ascertained without adding any risk of sepsis. Many patients at full term who have a tendency to carry the child past term, may be started in labor by the use of castor oil followed in two hours by intramuscular injections of 2 or 3 minims of obstetrical pituitrin. This dose is repeated every two hours until four doses have been given. These small repeated doses do not injure the mother and labor induced in this way is normal throughout. The method certainly offers less danger than the introduction of bags. While

speaking of pituitrin, its use when the cervix is fully dilated and the passage and passenger are not in disproportion has proven most valuable and often relieves the physician of the responsibility of a mid or low forceps operation. One-half c. c. doses are suitable for this purpose. Also the use of surgical pituitrin to relieve intestinal distention, and atony of the bladder after confinement is a useful measure.

Episiotomy is a simple surgical procedure that deserves more popularity with the physician. When it is apparent that a perineal tear is about to take place or a narrow pubic arch is crowding the head back towards the rectum, a lateral incision with knife or scissors at the junction of the upper two-thirds with the lower third on one or both sides of the vulva will allow a rapid birth of the head, shoulders and body without serious damage to the perineum or rectum. Oastler (4) in a recent article sums up the value of episiotomies as follows:

1. They save many mothers from exhaustion.
2. Save the perineum.
3. Do no pelvic harm.
4. Diminish the risk to the child. A few deep sutures of chromic catgut will unite the deeper structures and the mucosa while interrupted silk worm gut sutures serve best in the skin and for reinforcement.

During a long first stage of labor when the patient has been fatigued and the pains have become weak and irregular (a state often seen in dry labors) small doses of morphia, 1-8 to 1-4 grain repeated in six to eight hours, will give the patient a much needed rest, so that the pains come on with renewed vigor and interference is not necessary. This simple treatment does not materially lengthen the first stage.

Many of the serious errors in obstetrical practice are made by the physician during the third stage of labor. After the child is safely delivered, it is natural for the physician to wish rapid separation and expulsion of the placenta. One of the most common causes of post partum hemorrhage is a premature attempt to express a placenta that has not completely separated from the uterine wall. Cotyledons and placental tags are left in the uterine cavity; time is not allowed for clotting and plugging of the venous sinuses and hemorrhage follows. Another dangerous practice is the routine removal of the placenta by the manual method. During delivery the gloved hand and gown sleeve have become contaminated, also the vulva is often far from sterile. Manual removal of the placenta under these conditions is exceedingly dangerous from the standpoint of sepsis. The hand and field should be as clean as when the surgeon enters the peritoneal cavity. In fact more danger is attached to manual removal of the placenta, for the venous sinuses offer a fertile medium for bacterial growth and sepsis; pelvic thrombosis and phlegmasia alba dolens may follow this procedure. Usually if the physician will wait 20 to 30 minutes after the birth of the child, the placenta will separate and can be expressed without any danger.

During the puerperium there are several very valuable and useful practices. I will briefly mention some of them. The intramuscular injection of sterile ergot after labor. By some this is used routinely as a preventive measure against hemorrhage. Where considerable vaginal manipulation has been necessary or where there is special danger of sepsis, a course of ergot, that is 1-2 drachm of the fluid extract given by mouth every four hours until 6 doses have been given, will close the uterine sinuses and often prevent infection. This same course given later in the puerperium hastens involution of the uterus. Posture during the puerperium is very important. The patient who spends most of her time in bed in the lateral Simm's position or sleeps on the abdomen, will rarely have a retroversion following confinement. Also the urinary outlet through the ureters is not obstructed. If the subinvoluted uterus falls into a retroverted position the knee-chest position after the eighth day will often correct it. If there has been a repair of lacerations the locial flow does not pass over the suture line when the patient is in the lateral position. When an episiotomy has been performed on one side, the patient should be encouraged to rest on the opposite side.

A few suggestions about the care and management of the breasts might be useful. If the first cathartic is given about the third or fourth day, using enemas if necessary up to that time, and if the cathartic is a saline one, the patient will rarely suffer from engorged, painful breasts. At the same time the liquid intake should be reduced and the breasts snugly bandaged; sometimes the ice pack is useful. Cleanliness and fairly long intervals between nursing will prevent infection.

Colon and other infections of the urinary tract are by no means rare manifestations after delivery. Surgical pituitrin will often save catheterization and a beginning cystitis will respond quickly to the following plan; give sodium bicarbonate in large doses until the urine is made alkaline, then discontinue the sodium bicarbonate and force liquids and urotropin.

The sudden change in reaction of the urine often clears up a bladder infection.

When the puerperal patients should sit up is not a matter of routine but is an individual question. The physician who carefully watches his patient is able to decide this question wisely. Post partum care should extend over several months if we hope to prevent many of the crippling complications attending child birth. It is usually six weeks and often longer before the pelvic organs regain their normal size and position so that some attention should follow the patient after she sits up and the physician ceases his daily calls.

I take no credit for the practices outlined in this paper. They are probably far from ideal but they have served me well in my obstetrical work and I trust that they may be of value to other physicians who are striving to give their best to the obstetrical patient, thereby reducing maternal mortality in this country and bringing additional honor to our great profession.

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"PERNICIOUS ANAEMIA OF PREGNANCY."

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The so-called pernicious anaemia of pregnancy is a form of haemolytic anaemia, which remains quite distinct from true pernicious anaemia. There has been very little reference made to it in text books because of its supposedly rare occurrence. Yet I have seen no less than eleven cases of the disease in the past six years and recently while reviewing the literature on pernicious anaemia, I was surprised to find so many references to cases of that disease beginning during the puerperium. Furthermore, I am inclined to believe that deaths from puerperal anaemia have been reported as due to malignant endocarditis, because the symptoms of these two diseases resemble each other in many respects.

Evidently puerperal anaemia is not so rare as we have been lead to suppose and surely every practitioner who comes into contact with puerperal women should be familiar with the symptoms and treatment of a disease which has a reported mortality of from 60 to 80 per cent.

Puerperal women with anaemia should be carefully studied for the following reasons:

1. Since its first description by Walter Channing in 1842 (1) puerperal anaemia has frequently been mistaken for one of two invariably fatal maladies, ie., pernicious anaemia or malignant endocarditis.

2. The newer methods of blood transfusion offer a very encouraging prospect for more beneficial treatment. Of the eleven cases I have seen, nine have fully recovered following transfusion.

3. The literature and the teaching in text books concerning this subject is full of confusion, mostly because there are other forms of anaemia which complicate pregnancy and the puerperium. The anaemias associated with acute and chronic haemorrhages and the anaemias secondary to infection are especially at fault in this regard. Osler (2) recently attempted to classify all the anaemias complicating pregnancy and the puerperium. At the same time he suggests that the onset of puerperal anaemia may begin some weeks before term. Dr. Richard Cabot (3) has also favored this idea and there are a number of instances in the literature to support his opinion. These important questions can easily be settled in the future by the general practitioner, who has the opportunity to know so much more about his patients than can by any means be discovered about persons who flit through a hospital. It is by this means that the diagnostic mistakes of the past will be avoided in the future.

The usual clinical picture develops gradually following normal delivery. The most remarkable feature of the disease is, of course, the anaemia, but it is not unusual to find cases where the fever appears early in the foreground and remains the most annoying symptom for several weeks. As a rule, the patients retain their panniculus, while soon there develops a jaundice, varying from a pale yellow hue to a well marked golden yellow color. It is often remarkably variable in appearance and when seen together with the palor and the thick panniculus, it has a tendency to give the skin a waxy lemon yellow appearance like that observed in patients with pernicious anaemia. The stools are normal in color and the urine is free from bile, but urobilin in excess is frequently demonstrable. Other symptoms develop which are common to all forms of severe anaemia. Symptoms such as asthenia, palpitation of the heart and dyspnoea are constantly complained of, while the murmurs heard over the heart have sometimes been found to be very disconcerting, so much so that when considered together with

the anaemia, the jaundice, enlargement of the spleen and the leucocytosis, may lead to a diagnosis of endocarditis. But the absence of multiple emboli and positive blood cultures serve to differentiate these two diseases. Also the anaemia associated with malignant endocarditis is of the secondary type while that of puerperal anaemia is of the primary type.

Evidence of blood destruction is present from the beginning and this process may go on to such a considerable degree as to terminate with aplastic marrow accompanied by a blood picture which shows very little or no evidence of regeneration. However, the usual blood picture is that of abnormal blood destruction with signs of marked regeneration in contrast to the picture seen in cases of simple secondary anaemia. As the anaemia increases in severity, a leucopenia may develop, but the chief features of the typical fully developed blood picture, are a leucocytosis, a high color index and the presence of many neucleated red cells, with a considerable abnormality in the shape of red blood cells. This blood picture is in a great measure responsible for the confusion which exists between this disease and pernicious anaemia; the blood picture of puerperal anaemia will, however, be found to differ from that of pernicious anaemia in one very important respect, namely, the absence of a marked general macrocytosis accompanied by a sufficient number of abnormally shaped macrosytes. In addition to this the presence of a leucocytosis helps to make the difference complete. Another important differentiating point is the absence of the cord lesions so common to pernicious anaemia.

Fever, often reaching as high as 104 F, always complicates the clinical picture and it is forever suggesting an infection as the sole cause of the whole disturbance, but try as one will, no evidence of infection can be found. Blood cultures are repeatedly negative and autopsies on patients who have died from the disease disclose no evidence of infection. Such negative findings however, do not prove that puerperal anaemia is not caused by sepsis. In fact, the fever, the frequent leucocytosis and the chronic haemolytic anaemia support this assumption. But, notwithstanding these statements, the etiology is still obscure and the infectious theory difficult of proof which offers another very good reason why these cases should receive more consideration than they have had in the past. It is evident that proof should take the place of conjecture and our knowledge of puerperal anaemia will never advance until the general medical profession take sufficient interest to report their cases.

TREATMENT.

The treatment of puerperal anaemia consists of the usual general measures such as rest in bed, fresh air, freedom from worry and mental strain, etc. The diet and care of the digestive system are of great importance because metabolic disturbances are not uncommon in anaemia. This will require forced feeding to establish nitrogen equilibrium; thus permitting a nearer normal basal metabolism. A diet rich in iron containing foods is desirable. Hydrochloric acid should be given in large doses as it is well known that this acid is frequently subnormal or absent from the stomach contents.

Special medication such as the administration of arsenic and iron seem to be of very little benefit early in the disease. The transfusion of whole blood offers the most satisfactory and encouraging opportunities for more frequent and earlier cures. A detailed discussion of the various methods of transfusion cannot be discussed here, but there are a number of important points which ought to be emphasized. Emphasis therefore, is placed on the following points. First, the intramuscular injection of blood, defibronated or otherwise, is of little or no value as compared to transfusion. Furthermore, it is to be remembered that no patient is too sick to receive a transfusion. I have seen patients in a most helpless state show remarkable gains following this procedure(4). Also transfusion should be used at the earliest possible moment, as soon as the diagnosis can be made. It should be realized that transfusion is not essentially a method of last resort.

A healthy Wassermann negative donor, who can afford a reduction in blood volume should be secured and tests for blood compatibility should be made in every instance. I think that the direct transfusion of blood is the best method to be used but the citrate method may be tried as I have seen it give good results early in the disease. In my experience, the quickest response and the most marked improvement has followed the use of the direct method. (4) Furthermore, I advise direct transfusion of blood in every case where the hemoglobin is below 15 per cent.

Following transfusion, treatment with arsenic and iron seem to be of benefit, Fowler's solution by mouth and hypodermic injections of iron citrate are recommended.

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THE STATUS OF CRIPPLES IN DETROIT.*

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Ignorance is the term which must be used in any description of the situation with respect to cripples in any state, city, or smaller unit of government with two exceptions which will be noted later. Most communities have a self-satisfied feeling in the way the indigent sick are cared for. They point with pride to their hospitals, their dispensaries, the child-welfare associations, the visiting nurses, the tuberculosis sanitariums, maternity homes, orphan asylums, insane hospitals, and the activities of the Red Cross and the Salvation Army. These are things of which we may well be proud for never in the history of charitable endeavor has so much been done as is now being done for the relief of the sick, the lame, and the blind. The recent war served to demonstrate to ourselves to what extent we were willing to extend the helping hand when the need was forcibly brought to our attention. But it must be remembered that with the need remaining the same, a martial setting has the power to focus the attention as has nothing else in the world. For example, the death every year of 200,000 in the U. S. from the preventable disease, tuberculosis, scarcely causes a ripple in the surface of our daily lives, and this in spite of the fact that a campaign of education and appeal has been carried on for years. Let us take the situation of the cripple. Every year in the U. S. there are more people maimed and killed in industrial pursuits than during our entire participation in the world war. And yet it took a great crisis in our country's history to put upon a workable basis a plan of treatment which had for its ultimate end functional restoration of the disabled. Previous to the war there were only about 75 medical men specially trained along these lines in the entire country. Realizing the need for such specially trained medical officers the government, by intensive methods, trained and assigned to active duty no less than 800 of such men, and established physiotherapeutic departments and curative workshops in all the larger general hospitals for the treatment of selected cases. No such institutions exist for the treatment of similar cases arising in civil life although the type of cases occurring in industry is very similar to military casualties and the number just as great. In any program then, having to do with the public responsibility for the care of the cripple, either congenital or industrial, a survey of the local situation—a sort of stock taking is essential.

Only one state in the Union has made a seurvey of its cripples—Massachusetts—and that investigation carried out in 1905 established the fact that there were in the state 17,134 cripples which gave an average of 5.7 cripples per 1,000 population. I will not go into details of the Massachusetts report, as there is a more recent report in the Cleveland survey of 1916, except to state that the inclusion of rural districts in a state-wide survey does not alter in any material respect the findings of a later survey where only city dwellers were considered. There is a marked similarity between these two reports.

Taking the Cleveland statistics and revising them to apply to Detroit is in general not unfair for there are certainly greater differences between Massachusetts and Cleveland than between that city and Detroit. Certain reservations for known differences will be made in definite instances. Making such a revision is what I have done. Cleveland is, geographically, much the same as Detroit, climatic conditions are the same, the proportion of foreign-born differs but little, the method of housing is better here, both cities are industrial centers, and the cripple situation in Cleveland in 1916 per 1,000 population should bear a pretty definite relation to Detroit in 1920. The population of Cleveland in 1916 was 674,000 and the population of Detroit is assumed to be one-third larger in 1920 which gives a population of 898,000.

Table I—Cripples in Detroit—estimated from Cleveland survey.

	Number and per cent distribution					
Age at time of survey	Total	Per Cent	Male	Per Cent	Female	Per Cent
All ages	5481	100	3517	100	1964	100
Under 5	220	4	117	3	103	5
5—9	555		292		263	
10—14	473	18	277	16	196	22
15—19	401	7	225	6	176	9
20—24	387		249		137	
25—29	394		297		97	
30—34	356	41	245	46	111	33
35—39	399		293		108	
40—44	398		278		119	
45—49	355		247		108	
50—54	365		254		111	
55—59	349	13	229	14	120	11
Over 60	929	17	513	15	416	20

Table 1. According to the estimate there are in Detroit 5,481 cripples, of whom 3,517 are males and 1,964 are females. Grouping the cases according to age, making five years the group period, we find that the largest group—555—are between the ages of 5 and 9 years excepting the group "over 60" which is not limited by the 5 year period. The next largest

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number is in the third group. From 15 to 59 years cripples are pretty evenly distributed in the various groups, ranging from 349 to 401. If we roughly classify the cases in periods of "infancy," "school age," "industrial activity" and "age of reduced activity," with the ages 5, 19 and 49 as the terminal years in the first three classes, it is found that 4 per cent of our cripples are under 5 years of age, 25 per cent. are of school age, 41 per cent. are in the productive period of life, and the balance—30 per cent.—50 years of age and over.

In comparing the relative and absolute frequency of crippling conditions by age periods among males and females the following interesting facts are noticed. Sixty-four per cent. of all cripples are males, 36 per cent females. This is due no doubt to the greater liability to injury in the industrial life that males lead for it is seen that in infancy sex seems to have very little influence but as soon as the environment of the boy becomes different from that of the girl in that the hazard is greater, the number of cripples among boys increases. This extra hazard continues to be a factor in the life of the male for the remaining periods. It must be kept in mind that these figures represent the ages at the time of survey and not the ages at the time of occurrence. The possible sources of error in this and following tables will be indicated later. Assuming for the time being, however, that this table is reasonably accurate we see that there are 1,449 cripples of school age in the city and the query immediately arises as to how many of these are able to attend the regular school courses, how many would be benefitted by special classes in special schools maintaining the regular curriculum, how many are not attending any school by reason of being under treatment or because of inability to get to the school building from physical disability, and finally how many are not in regular or special schools because of mental as well as physical defects. Some of the following tables have a bearing on these queries:

Table II. Age at Time of survey. Occurrence of Disability. Adapted from Cleveland Survey.

	Occurrence				Survey	
Birth, 4 years	1867		34%		220	4%
5—9 "	469		8%			
10—14 "	392	(861)	7%	(15%)	1028	18%
15—19 "	336		6%		401	7%
20—24 "	333		6%			
25—29 "	345		6%			
30—34 "	288		5%			
35—39 "	239		4%			
40—44 "	251		5%			
45—49 "	242	(1698)	4%	(30%)	2288	41%
50—54 "	215		4%			
55—59 "	177	(392)	3%	(7%)	714	13%
60 and over	364		7%		929	17%
Not stated	63		1%			
Total	5481		100%			

Table II gives the ages at the time of occurrence of disability and compares these ages with the ages of the table just given. Here we find that 1,867 cases or 34 per cent. occur at birth or during infancy with the next 5 year period from 5 to 9 the next most numerous with 469 cases. The industrial period accounts for 30%, the numbers gradually decreasing as the groups are taken up in order. The important fact here brought out is that the problem of the cripple is a medical and an educational problem of childhood to a large extent. From a medical standpoint the community must ask itself if it possesses the institutions, hospitals, clinics, dispensaries, and convalescent homes, all properly equipped and manned by specially trained personnel to care for the handicapped child. The community also must ask itself if it has provided educational facilities of the ordinary or special types, according to the need, whereby the crippled child may receive instruction, both during and after treatment, to the end that its handicap may be lessened and the economic status of after life improved.

Table III. Form of Disability. Estimated from Cleveland Survey, 1915-1916.

Loss of one hand or arm	251—	4%	
Loss of both hands or arms	8—	1%	
Defect of one arm or hand	665—	11%	
Defect of both hands or arms	56—	1%	17%
Loss of one foot or leg	621—	11%	
Loss of both feet or legs	36—	1%	
Defect of one foot or leg	2051—	37%	
Defect of both feet or legs	487—	9%	58%
Loss or defect of one or both arms arms combined with Loss of defect of one or both legs	443—	7%	7%
Deformity of body	265—	5%	
Paralysis of body	8—	1%	
Not classified	89—	1%	7%
Crippled body combined with crippled legs and arms	591—	11%	11%
	5841—	100%	100%

Table III gives the form of disability and the assumption is made that these figures are correct for Detroit. Seventeen per cent. of the cases are disabled in the upper extremity, 58 per cent in the lower extremity. Seven per cent. show defects of the trunk, and 11 per cent. have defects of trunk and extremities. In both the upper and lower extremities amputations are in the minority as compared with defects, and by defects are meant all other crippling conditions. Defects of the foot or leg form by far the greatest class with 2,051 cases, or 37 per cent. of the total, followed by defects of the arm or hand with 665 cases or 11 per cent. of the total.

Table IV. Age at time of survey.

	0-5	5-14	15-19	20-49	50-59	60 & over
Loss of one or both	0	5	3	171	52	28
hands or arms ---	0%	2%	1%	66%	20%	11%
Defect of one or both	32	80	39	401	86	73
hands or arms ---	5%	11%	5%	56%	13%	10%
Loss of one or both	0	43	31	411	83	80
feet or legs ------	0%	7%	5%	62%	14%	12%

Defect of one or both feet or legs	139	605	216	849	315	424
	6%	24%	8%	33%	12%	17%
Combined leg and arm disability	13	82	20	143	60	115
	3%	21%	4%	32%	14%	26%
Deformity or paralysis of body	7	132	56	127	15	27
	2%	36%	16%	35%	4%	7%
Combined arm, leg and body disability	29	71	37	187	84	183
	5%	12%	6%	32%	14%	31%
TOTAL	220	1028	401	2288	714	929
	4%	18%	7%	41%	13%	17%

Table V. Age at Occurrence. Adapted from Cleveland Cripple Survey.

Years	0-5	5-14	15-19	20-49	50-59	60 & over
Loss of hand or arm—one or both	7	32	47	155	15	4
Defect of hand or arm—one or both	155	99	93	316	47	16
Loss of foot or leg—one or both	27	157	72	351	25	23
Defect of foot or leg—one or both	1159	400	92	501	183	184
Combined leg and arm disability	153	32	7	137	44	68
Deformity or paralysis of body	164	69	5	17	4	7
Combined leg, arm and body disability	179	44	19	204	73	61
Not classified	27	39	1	17	1	1
TOTAL	1867	861	336	1698	392	364
	34%	15%	6%	30%	7%	7%

(Age not stated in 1%)

Table IV gives the age at time of survey combined with the anatomical distribution of the various disabilities. This shows that amputations, which are the result of industrial or other accident, occur in greatest numbers during adult life while defects are common in both children and adults. This is more strikingly brought out in Table V which gives age at occurrence combined with distribution. The greatest group in this table is that showing 1,159 defects of foot or leg occurring in children while under five years of age, 501 disabilities of foot or leg occur between the ages of 20 and 49, but as this is a span of 30 years the group is relatively not as important as the 10 year span from 5 to 14 in which 400 cases occur. Again we are reminded that it is the children who suffer most severely from physical handicaps.

Table VI. Main Causes of Disability. Adapted from Cleveland Survey.

	Number			Per Cent Distribution		
		Male	Female		Male	Female
Congenital	401	181	220	7%	5%	11%
Accident at occupation	624	609	15	11%	17%	1%
Other accident	1764	1288	476	32%	37%	23%
Infantile paralysis	700	385	315	13%	11%	15%
Other diseases	1916	965	951	34%	28%	46%
Not stated	176	88	88	3%	2%	4%
	5481	3517	1964	100%	100%	100%

Main causes of disability are illustrated in Table VI. Seven per cent. are congenital, 11 per cent are caused by accident at occupation, 32 per cent. by other accident, 13 per cent. by infantile paralysis, and 34 per cent. by other diseases, bone tuberculosis, etc. Women suffer very little from occupational accidents and are not as prone to any form of accident as are males. Three of the five causes given apply to children especially—congenital conditions, infantile paralysis, and diseases of bones. The first two alone comprise one-fifth of the total number of cripples with 1,101 cases.

Table VII. Causes of Disability in Children—Estimated. 0-15 Years. At Time of Survey.

Congenital	199	16%
Accident	116	9%
Infantile paralysis	509	41%
Tubercular bones and joints	185	15%
Other diseases	197	16%
Not classified	42	3%
	1248	100%

Of the 1,248 crippled children under 15 years of age estimated to be in Detroit, 199 suffer from congenital defects, 116 from accidents, 509 from infantile paralysis, 185 from bone tuberculosis, 197 from other diseases, 42 not classified. This gives infantile paralysis as the largest single factor among children who are at present of school age or under. Forty-one per cent. of the total are from this cause. When it is realized that the number of infantile cases of all ages is 700 and that 509 of these are still under 15 years of age we begin to appreciate how recent is our problem for the proper treatment and education of these children. Has the community, the various charitable organizations, or the medical profession taken any steps to meet the special needs of these infantile cases?

Table VIII. Age Distribution of the Blind in Detroit—Estimated from Cleveland Survey.

Under 15 years	63	7%
15—60 years	396	44%
60 and over	441	49%

Age Distribution of the Crippled in Detroit—Estimated from Cleveland Survey.

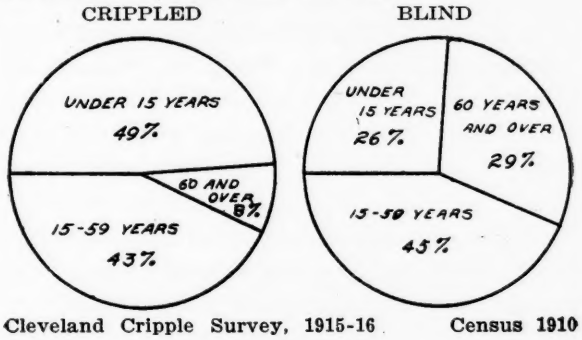
Under 15 years	1206	22%
15—60 years	3343	61%
60 and over	932	17%

Table VIII gives the age distribution and the number of blind in Detroit as compared with the crippled from which it is gathered that there are six times as many crippled as blind, that the problem of the blind is largely one of middle life and old age instead of one of childhood. Another query comes to mind—has society provided as amply for the cripple in proportion to his numbers and his need as it has for the blind?

This ends the series of projected tables. Let us now examine the possible sources of error and make the necessary corrections. I have repeatedly heard the following statements: "Detroit has no cripple situation. Everybody is at work and receiving good pay. There is no large indigent class requiring attention. People are able to pay and are paying for what medical attention they need. Thousands of workmen have flocked to Detroit in the last three years to share in our material prosperity but because of their

inability to find homes have left their families behind. These men are able-bodied and so present no problem. Detroit is a city of detached homes and as a result we have none of the diseases incident to a tenement city. Detroit cannot be compared in any way to Cleveland because our standards of living are infinitely higher and our civic responsibilities carried as is done in no other city in the United States." These then are the statements. Let us hope they are true for civic pride is a valuable asset to any community. But hope and civic pride should not deter us from searching the facts and acting on the facts when found.

Comparison of Age at Occurrence of Disability Among the Blind and Crippled.



Cleveland Cripple Survey, 1915-16 Census 1910

It is true that many workmen have come to Detroit without their families and that for the most part these men are, or were, able-bodied. The net effect is to increase relatively the number of industrial cripples and to reduce, also relatively the number of crippled children. Detroit's population is undoubtedly better housed than the average city even in spite of the present over-crowded condition. We have no tenement districts to speak of and this factor reduces considerably the number of cripples who were made so by unhygienic environment. This applies particularly to tuberculosis. The table quoted gives 15 per cent. of all crippled children under 15 years of age as suffering from tuberculosis of bones and joints—a total of 185 cases for this city. On actual survey the number would undoubtedly be less than this. Detroit's population is at work and consequently better able to pay the private physician for medical attention to cripples and so there is a falling off of attendance at the dispensaries. The improved economic condition is not so much due to an increased daily wage, for the increased cost of living has largely neutralized this, but to be accounted for by the more continuous employment. A resume of the local conditions as corrected is about as follows—the total number of crippled children as given in the tables is probably slightly too large and the number of cripples charged to industry is without question underestimated—the final total comprising both classes remaining about the same. Of the 5,481 cripples estimated to be in the city, a larger proportion than usual are able to pay for medical and surgical attention, leaving a reduced but still considerable number to be cared for by charitable institutions.

What can the private or dispensary physician or surgeon do to restore the patient to a life of usefulness, for after all the need of society for a useful life is second only to the need for saving life? For an acute condition he can make use of the ordinary hospital, ordinarily equipped, and with the ordinary personnel. Then a few visits to the office or the dispensary and in the case of private patients, the bill, and all seems to be settled. This, however, is not the case. For the child there is the question of restoration of function, education or re-education during the long period of convalescence. For the adult the same things apply but with special emphasis on re-education in selected cases to the end that he may re-enter industry with the least possible handicap. I maintain that the proper treatment of the patient, whether rich or poor, in the office, the dispensary, or the hospital, is too large a problem for the physician or surgeon to solve within the four walls of an office or in a hospital as ordinarily equipped. A few changes here and there in our existing institutions, followed by the closest co-operation between the medical profession, the hospitals, the dispensaries, the Department of Health, the Board of Education, convalescent homes, recreation centers, and leaders of industry, will bridge the gap now existing in the continued and progressive treatment of our cripples. The mere ability to pay does not bring the necessary relief. It does, however, render the establishment of the proper facilities for such relief less expensive.

To make the proposition seem a little more real to us let us take a few illustrative cases.

A child with Pott's disease enters the hospital as a private or dispensary case. The necessary surgical and immobilization treatment is given and the child transferred as soon as safe to a convalescent school, maintained at state expense, on the ground that disease should not act as a bar to that education freely granted to the able-bodied child. From time to time the patient returns to the dispensary, the office or is visited at the school by his medical attendant. That education is given which best fits the child for the struggles of after life and must be individualistic. The teacher must possess the qualities of a nurse and social worker as well. As the child grows older and a cure has been

established the patient may be admitted to that technical training for which he is best fitted after which he should be able to make his own way in the world.

The next case is a child with infantile paralysis. While in the hospital all muscle groups are tested for power on the spring scales, vicious contractions corrected, and a course of massage electro-therapy, and remedial gymnastics started the benefits of this treatment being checked up periodically by the spring balance test. Finally for conditions uncorrectable by these physio-therapeutic methods, surgery and the fitting of braces is to be resorted to and the child transferred to the convalescent school where treatment in a modified form is continued. At the end of such a course of medico-educational treatment the patient will be in much better shape to enter the lists as a bread winner.

Let us assume the next case to be an industrial worker with a crushing injury to the right forearm and elbow. He receives first aid and the necessary surgery, restoration of function being hastened by the intelligent use of massage, active and passive exercises, hydro and electro-therapy, occupational and curative work—and by curative work is meant not merely something to occupy the patient's spare time but rather that work which has specific value in restoring function in the disabled member. Following discharge from the hospital it may be found that the injured arm is permanently crippled and that the man is unable to follow his former occupation. He then enters a trade school, either within or outside the factory in which he was injured, for the purpose of re-education to a calling which his previous education, his mental state, and his physical handicap permit. This re-education should be granted to the victim without cost to him, the compensation allowed by law to remain the same.

Such a program as this is not too much to ask on behalf of the handicapped. To grant the request it will be necessary that at least some of our hospitals provide means whereby the valuable physio-therepeutic adjuncts of treatment may be prescribed, that units of government establish convalescent schools free from the taint of charity and to which rich and poor may go without loss of self respect, and that industry be chargeable with the responsibility for re-education of its cripples.

What steps are necessary to a thorough understanding of the local situation? I should say first of all, a complete survey of all the handicapped in the city. We should know the total number of cripples, their ages, the age at which the disability occurred, the cause of the disability, the amount of reduction in earning power, the number attending regular or special schools, the number of children of school age not attending school and the reason therefor, the quality of service rendered by hospitals, dispensaries, and schools for cripples, the quality of training in the prevention and treatment of deformities given in medical schools, the facilities for the rehabilitation of the industrial crippie, the effect of workmen's compensation laws in retarding or hastening the return of the disabled to industry. When we know these things by direct evidence rather than by the round-about method I have been forced to adopt the solution of the problem will depend on the findings. Of this I am sure—that Detroit has a cripple situation and that the facilities for meeting that situation are inadequate.

804 Empire Building.

SEQUELAE OF ENCEPHALITIS LETHARGICA IN FOUR CASES.*

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1. Sufficient time has now elapsed for us to meet with cases of chronic encephalitis lethargica and to note some of the results produced by the acute pathology. It is possible at times to diagnose these cases by the sequelae of the disease much the same as we are able to diagnose an antecedent acute poliomyelitis by the resultant paralysis. It has been suggested that the two diseases are incited by different strains of the same causative infective agent with a modification of its virus. They are both sporadic in type and attack the central nervous system with resulting paralysis. But poliomyelitis is more destructive in character while the toxin of encephalitis is more irritative. The former usually comes in childhood and the latter is more common in adults. Likewise epidemics of poliomyelitis are in no way related to encephalitis epidemics. There are of course, many other points of distinction.

*Read before Staff Meeting Harper Hospital, Jan. 23, 1921.

2. Encephalitis seems to have a special, though not invariable, predilection for the brain stem. The brain has a pinkish appearance and the greatest pathology is usually seen in the mesencephalon, pons, and basal ganglia. Meningeal thickening and edema is frequent. On section especially, the gray areas around the aqueduct of Sylvius show punctuate hemorrhages. The characteristic lesion is a perivascular infiltration and an interstitial edema and this condition produces a temporary interruption in the nerve conductibility so as to produce the paralysis and differences in the reflexes. Thrombosis of the small vessels are frequently found and the perivascular infiltrations are of the lymphocyte variety. As a rule it attacks single cells or small groups of cells in many situations, and because of these diverse locations the many varied neurological findings are accounted for. In contrast to poliomyelitis there is no complete absence or destruction of the ganglion cells but varying degrees of chromatolysis. It is therefore not as extensive or as destructive as poliomyelitis.

3. The literature on encephalitis is a comprehensive one and contains many reports on the isolation of an infective organism. Loewe and Strauss (1) have been able to produce the disease experimentally in rabbits by injecting intracranially, the filtrate obtained from the washings of the naso-pharyngeal membrane of patients suffering with encephalitis. Characteristic lesions were produced in 78 per cent. of the experiments. But it can safely be said that the real causative agent has not yet been isolated. The infective nature, however, is obvious.

4. The symptomatology of this disease is a varied and protean one. From the pathology it becomes evident that there will be a multiplicity of clinical symptoms which resemble many forms of nervous diseases. Many classifications of types are found in literature but no hard and fast grouping is really possible. The mode of onset is also varied; some begin with acute catarrhal symptoms of the respiratory tract, others with malaise, headache, vomiting, general neuralgic pains just as in the prodomal period of other infections. There is fever, varying in uncomplicated cases from 99 to 102 degrees, pain in the arms and legs resembling muscular rheumatism—for which the disease is sometimes mistaken at the onset—delirium of a mild type is present for a period of a few days to a few weeks, lethargy appearing as a rule within the first few days is quite characteristic and is one of the principal symptoms upon which the diagnosis is based. Some cases, however, suffer from insomnia and never have the lethargic symptom while with others this often precedes the lethargy. The so-called Parkinson's mask is present in the majority of cases. The patients are usually easily aroused but lie motionless for hours. During the period of lethargy catatonia is frequently met with. Very characteristic, and present in perhaps 90 per cent. of cases, is a muscular fibrillation involving various muscles and muscle groups in the face, legs and abdomen. Asthenia is present in practically all cases and is an aid in establishing the diagnosis. Cranial nerve involvement is a most constant and striking symptom. Diplopia, usually transitory in nature—lasting from two to four days and associated with blurring of vision—appears early. Third nerve paralysis, frequently bilateral, with ptosis of the lids is the most frequent nerve involvement and was present 66 times in 115 cases. (Summarized by Dunn and Heagey.) (2) Inequality of pupils through paralysis of the ciliary and iris muscles is also frequent. The fifth nerve paralysis, when present, usually involves the masseter muscle branch and creates difficulty in chewing, while the sensory branch is less frequently involved and produces anesthesia of the face on the involved side. Next in frequency to third nerve paralysis is that of the 6th abducens. The external rectus innervator, producing an internal squint. This was present 40 times in 115 cases. The seventh nerve paralysis with dropping of corner of mouth, absence of wrinkling of forehead, lack of muscular tone on involved side is next in frequency. The chorda tympani branch, supplying the anterior two-thirds of the tongue producing taste disturbance is less pronounced. Disturbance of the other cranial nerves are of minor diagnostic importance. Disturbances in reflexes are not uniform as would be expected from the pathology. Babinski's sign is rather conspicuous by its absence and when present, is usually transitory. Cerebellar involvement with ataxia, nystag mus and vertigo are fairly frequent. Occasionally monoplegias and hemiplegias are encountered. Leucocyte counts average around 10,000 with about 72-80

per cent. Polys. The Wasserman test is uniformly negative. Spinal fluids have an average cell count of from 10 to 50 and in sixty-four examinations in 100 cases in the literature the cells averaged 16. Globulin is positive in 50 per cent. The mortality is about 20-30 per cent.

5. The duration of the disease brings us to the question its sequelae. According to the report of the English local government board (3) the duration of the acute illness is 21 days. The duration of the symptoms is still an open question. Dunn and Heagey (2) give 4 or 5 months for the duration of the facial palsies; the asthenia, depression, about seven months. The following four cases varying in duration from 14 to 22 months still have symptoms sufficient to give trouble. By coincidence they are all in adult males. All but one were in the hospital and diagnosed as encephalitis lethargica.

Only the positive findings will be given:

Case 1. M. M. Age 38. Was in hospital 17 months ago for encephalitis lethargica for which he was confined to bed six weeks. The subjective sequelae of which the patient complains is loss of memory, weakness, pain and twitching in the abdominal muscles, lack of ambition and restlessness. Objectively, the patient has a slow, slurring speech and answers questions painstakingly. Both pupils are sluggish; the left being larger than the right. During the examination of the abdomen fibrillation of the abdominal muscles was produced by percussion.

Case 2. P. G. Age 48. This man had encephalitis 22 month ago and was confined to bed in the hospital for 6 weeks. Because of the severity of his symptoms a fatal prognosis was given. At present the subjective sequelae of which he complains are lack of ambition, difficulty in talking, concentrating, poor memory and weakness of left leg. Objective sequelae are slow, slurring speech, inequality of pupils—left larger than the right—exaggerated patellars and fibrillary twitchings in the left leg. This case was seen by Dr. Jones, who concurs in the diagnosis of encephalitis lethargica.

Case 3. H. W. Age 47. 14 months ago this man had influenza followed by so-called rheumatic fever; was confined to bed in hospital for two weeks. His ankle and wrist joints were swollen and subsided in two weeks. April 4, 1920, patient strained his back while lifting a pole. Worked three days but did not feel well. Since then complains of headache, involuntary movements in abdomen and legs and says his rectum keeps "jumping." His legs are weak and he tires out easily. On questioning him further he says this was present soon after the Influenza attack. The objective sequelae are slow slurring speech, inequality of pupils—right larger than left—wrinkling of forehead, less on the left, tongue smoother on the left, exaggerated left patellar reflex spasmodic contractions of the rectal sphincter and twitching of the leg muscles, especially the left. A diagnosis of encephalitis lethargica was made in the hospital in April 1920 and he undoubtedly had this in Nov. 1919.

Case 4. J. W. Age 26. In Nov. 1919, 14 months ago he had severe pain in the head, arms and legs. Double vision was present for three weeks according to his statement. Persistent insomnia was very disturbing so that he often went for three nights without sleep. This lasted about 8 weeks and since then he sleeps about 4 hours a night. He had and still has, a feeling of weakness in both legs and jerking movements which irritate him. At no time was he confined to bed for his illness. Three physicians saw him at various times and told him it was nervousness. He has been unable to work since Nov. 1919 on account of his insomnia, weakness and restlessness. His memory remains unimpaired. The objective sequelae are unequalness of the pupils, the right being larger than the left, fibrillary twitchings in the leg muscles and exaggerated patellars. This case was undoubtedly an ambulatory encephalitis without the lethargy symptom.

All cases had negative Wasserman. Two had negative spinal fluid quite recently while case 3 had a negative report in the hospital.

Summarizing the four cases it is noted that three symptoms are common to all.

1. Weakness or Asthenia.
2. Inequality of pupils.
3. Fibrillary twitchings.

Three had loss of memory and slow speech while the fourth an ambulatory case without the lethargy was free from these symptoms.

The exact cause of these sequelae still remain unknown. Whether they are due to a chronic irritation by the toxin or a release of nervous activity by interference with control remains to be seen.

In conclusion: the persistence of symptoms resulting from encephalitis 14 to 22 months after the onset of the disease shows that the exact duration of the disease is still problematical.

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2407 Woodard Avenue.

The Journal
OF THE
Michigan State Medical Society
ISSUED MONTHLY UNDER THE DIRECTION OF THE COUNCIL

A. L. Seeley, Chairman ---------- Mayville
L. W. Toles ---------- Lansing
R. S. Buckland ---------- Baraga

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The Society does not hold itself responsible for opinions expressed in original papers, discussions, communications, or advertisements.

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March

Editorials

ANNUAL MEETING CALL FOR PAPERS.

Section Officers hereby announce that those of our members who desire to present papers for acceptance and placement upon the sectional programmes for our next annual meeting, that such submission should be made at once. A list of section officers will be found in the front advertising pages of the Journal. Section officers have been engaged in the preparation of the scientific program for several weeks. Please correspond with these officers direct in all matters pertaining to their programme and the submission of papers. The official programme will be published in the May issue.

DUES.

By the action of the House of Delegates, all members whose current dues are not paid on or before April 1st are placed on the suspended list. We recommend that you avoid such suspension by prompt remittance to your county Secretary. Please do not necessitate removal of your name from our list of members in good standing.

ASSOCIATE EDITOR.

Unintentionally we failed to acknowledge in our annual report the work accomplished by our associate, Dr. Guy L. Connor. By his diligence many items that otherwise escaped our attention were submitted for publication and enhanced the value of the Journal. He has supplied us with editorial material and the news items of Detroit and vicinity. His advice and judgment has aided us on many occasions in solving confronting problems. We are sincerely appreciative of all that he has done in behalf of the Journal. It was unpardonable to not have acknowledged it in our report. We are well aware that Guy will promptly give us a calling for this acknowledgment, never the less we feel it is due him and thus cheerfully record it to his credit.

CORRESPONDENTS.

We have always felt that The Journal should include the medical progress and activities of the profession for the information of its readers and also to preserve such record for future reference and historical purposes. To incorporate these features in our publication the Council passed a resolution providing for the appointment of such correspondents from each Councillor District by the Councillor. The following correspondents have been appointed:

County	Doctor
Kalamazoo Academy	Dr. C. E. Boys, Kalamazoo.
Berrien	Dr. Edw. J. Witt, St. Joseph.
Cass	Dr. Geo. W. Greene, Dowagiac.
Charlevoix	Dr. Harry E. Shaver, Boyne City.
Cheboygan	Dr. F. C. Mayne, Cheboygan.
Alpena	Dr. C. M. Williams, Alpena.
Genesee	Dr. Arthur C. Blakeley, Smith Bldg., Flint.
Muskegon	Dr. Frank W. Garber, Muskegon.
Eaton	Dr. Phil H. Quick, Olivet.
Calhoun	Dr. Wilfrid Haughy, Battle Creek.
Monroe	Dr. Bryce Miller, Monroe.
Lenawee	Dr. I. L. Spaulding, Hudson.
Bay	Dr. L. S. Foster, Bay City.
O. M. C. O. R. O.	Dr. C. C. Curnalia, Roscommon.
Newaygo	Dr. C. D. Long, Fremont.
Huron	Dr. Mordiu, Bad Axe.
Sanilac	Dr. Mc Caul, Croswell.
St. Clair	Dr. Heavenrich, Port Huron.
Lapeer	Dr. Parker, Lapeer.

The Editor will outline in fuller detail the duties of these appointees in a personal communication. We believe such a plan will increase our members' interest in their publication. Incidently we call attention to the news notes and society news of this issue.

"INASMUCH AS YE HAVE DONE IT UNTO THE LEAST OF THESE MY BRETHREN, YE HAVE DONE IT UNTO ME."

A PLEA.

Peace comes elsewhere, but Hunger knows no Armistice in the Near East. With each six months that pass, some seemingly ultimate blow falls on Armenia and the Christian nations of the earth turn away at the sight with horror and relief—horror at the sight of blood, relief that it's all over at last—but out of the ruin and death of each fresh defeat and massacre, the Armenian people rise again to rebuild their fortune as best they may. Their stubborn persistence under continued attempts at extermination, is an extraordinary phenomenon, but the spectacle of one nation trying to club another to death, and failing because of the unquenchable vitality of its victim, is so unpleasant that we try to forget it. We do forget it, and the next news despatches informs us of another calamity. We cannot do much about it as individuals, and we don't, for reasons mainly political, do anything about it as a nation. The club descends the victim writhes, we hold our newspaper before our faces and read the stock quotations.

In that land of desolation and death, Near East Relief, under a grant of Congress, has been laboring for five years. Its work has been, and continues to be different from the work of similar organiatzions in other wartorn areas of the world. In the Near East the task is not only to feed, but to clothe and shelter a race of people driven by the despicable Turk into a small section of their homeland, far beyond the borders of the Turkish Empire—a broken, tortured, fugitive people without arms or tools, without food or shelter, in an unwanted corner of the world to starve. Into this cold mountainous region refugees—women and children—homeless and without food, are marching daily. Truly, it presents a wretched picture and in all this land of desolation and sadness, there is but one big bright hope and that comes from not out of the East as in the olden days, but from out of the West. America's big, warm, generous Christian heart that pulsates love and kindness to a forlorn and victimized people whose lot has been indescribably bitter.

Each morning, in two hundred and twenty-nine orphanages, one hundred and ten thousand little children, awake and kneel and pray, and in their infant prayers, they always remember to ask that "The Almighty bless America," for these little ones are being fed, clothed, sheltered and educated, thru America's contributions to Near East Relief.

This year Forty-two hundred orphans confidently await Michigan's response to their appeal. The State Committee for Michigan, made up of our best citizens, have been giving conscientiously of their time, energy, and money so that our State shall not fail in its responsibility to these little unfortunates.

On account of the financial conditions, there is a serious question whether sufficient funds will be raised to meet this obligation. A number of business and professional organizations are helping. The Michigan Medical Society must do no less than its full share.

It costs $180.00 a year to provide the food, clothing, shelter, and education for one of these orphans. We have been allotted fifty, which means that on or before April 1, 1921, if we measure up to our job, that we will turn over to the State Committee for Near East Relief $9,000.00, and will be assigned fifty of these kiddies for our own.

Contributions of twenty per cent of our professional income for one day will do the job. Can we do a bigger, more constructive, task than this?

This editorial constitutes our appeal for these orphans, and remember, although we may get tired of giving, these little children also get tired of starving. **Your first thought is your best thought. Do it now!**

Dr. F. C. Warnshuis, Secr'y, State Medical Society, 415 Powers Theatre bldg., Grand Rapids, Michigan.

I hereby agree to contribute to the **State Medical Society Near East Relief,** 408 West Fort Street, Detroit, Michigan the sum of

_____Dollars, in equal monthly payments as indicated below.

$15 per month
$10 per month
$ 5 per month
$ Cash with pledge

_____
signed

_____
street

_____
city county

Make all checks payable to Near East Relief.

I WONDER

I wonder if I have the right
To let myself forget to care
How children shiver in the night
Where all is dark and cold and bare.

My little ones are free from dread
And sheltered safely from the storm;
Their eyes are bright, their cheeks are red,
Their laughter glad, their clothing warm.

But other little ones must weep,
And face new dread with each new day,
Where Hunger's fangs bite very deep
And Want sits like a ghost in gray.

I have no need to share the blame
If pallor dims the orphan's cheek;
I have not made the cripple lame,
Nor taken from the poor and weak.

If children who are hungry sigh,
If others who are cold complain,
No guilt lies on my consience—I
Have never wronged them for my gain.

But, knowing how they weep at night,
Where all is dark and cold and bare,
I wonder if I have the right
To let myself forget to care?

—S. E. Kiser.

MARCH IS STATE MEDICAL SOCIETY NEAR EAST ORPHAN ADOPTION MONTH. LET'S GO!

Dr. F. C. Warnshuis, Secr'y, State Medical Society. 415 Powers Theatre Bldg., Grand Rapids, Michigan.

Please enclosed find the sum of

_____Dollars, which is my contribution to the **State Medical Society Near East Orphan Adoption Fund.**

_____
signed

_____
street

_____
city county

Make all checks payable to Near East Relief.

DEAN VAUGHAN RESIGNS.

Although for several months past vague rumors had reached us that affairs were being so shaped in the medical department of the University as to call for changes in the faculty and that the resignation of Dean Vaughan would follow, we lived in the hope that the latter change would not be accomplished. During the month, newspapers announced that Dr. Vaughan had tendered his resignation, to President Burton, to become effective at the close of the present college year. This resignation announcement will be received with manifest regret by the profession at large.

Personally, it was not our privilege to have been one of his students. We have, however, been permitted to come in contact with him upon numerous and varied occasions and as we gained a new viewpoint of his wisdom, scholarly attitude, and broad-mindedness, we found our reverence and respect for him to grow. As we perceived his genius manifest itself, his judgment attested to and his accomplishments record their progress in our medical sphere we automatically acknowledged his leadership. Then as we witnessed the love and esteem with which he is held by hundreds upon hundreds of Doctors throughout the country and personally having been the recipient of his kindnesses, council and assistance we held him in filial regard.

We remember eight years ago when in attendance at the American Medical Meeting in Minneapolis when he was nominated and elected President of our National organization, men from every state endorsed his nomination in personal conversation, accompanied by expressions of love and respect for Dean Vaughan. We all remember Dr. Work, President of the A. M. A., stating at our meeting in Kalamazoo, last May: "It is unnecessary to say—you all know that Dr. Vaughan is already known as the greatest man in American medicine in Michigan, and a great many of us believe he is the greatest man in American medicine today." This latter sentiment is more prevalent in this country today. Space will not permit us to set forth the reasons that support such a declaration and appraisal. Dean Vaughan's resignation will be a distinct loss to the University not alone by reason of sentiment but from prestige and ability. We deeply regret that it has been accepted.

We are not informed as to his future plans but we do know that it is the sincere wish of our members that whatever they may be we all tender him our hearty wishes for continued health and happiness. We shall never relinquish our right to acknowledge his leadership. We pledge our sincere concern in added attainments that he is sure to acquire and achievements that will be wrought by him for and in our behalf and welfare as well as that of the public at large. His "Boys" will ever remain "His Boys" and well wishers.

Editorial Comments

We are not concerned so much with the practice of chiropractic or any other cult that may hold out to cure or alleviate human ills. What concerns us most is that the followers of these cults shall be compelled to receive such training and instruction as will enable them to recognize the limitations of their treatment in the light of our knowledge of etiology and pathology of disease. This, in order that a trusting public may not be imposed upon by having the true pathology go unrecognized by these practitioners and subsequent increased complications prevent a cure or relief that might otherwise have been accomplished. We must awaken a public realization that no individual is competent to diagnose or treat a given condition with but a ninety day education. This is the basis upon which information regarding these cults must be imparted to the public.

Modern dances are receiving considerable attention as to their evil influences by the better type of individuals. We adventure to declare that the "jazz," "shimmy," "cheek to cheek" and similar "holds" are due for the discard. But it isn't these dances that alone tend to demoralize the rising generation. The fault lies largely at the door of parents who seem to have forgotten that nine and ten o'clock are bedtime hours for children and who have been permitting them to remain out until one or two o'clock. Small wonder that over 20 per cent of pupils in a certain high school failed to obtain passing marks in their recent examinations.

It will be remembered that at the time a special meeting of the House of Delegates of the A. M. A. was called last November, Wayne County adopted a resolution requesting Michigan Delegates to oppose the increasing of the subscription price of the *Journal of the A. M. A.* The State Secretary was the only delegate from Michigan that attended that special meeting and when the vote was taken he voted to increase the subscription price. Some criticism of that vote now comes to us. If the critics will read the report of that special meeting, the statement of finance, the obligations incurred by the A. M. A. which must be paid out of the published amount of surplus and the other statements made by the trustees of the A. M. A., we feel assured that had these facts been available before the Special Meeting no opposition would have been expressed. In view of them the Secretary did not see

how he could oppose an increase of subscription price, nor could he feel he was recording Michigan's attitude if he voted "No." We are of the opinion that our vote represented our members desires, in the light of the statements submitted revealing the necessity of a temporary increase in subscription price. These critics are again referred to the minutes of that meeting.

Remember your income tax returns are to be filed by March 15th. We trust you have had a pleasant time working over that puzzling blank.

Doctor, if you haven't paid your dues you are in temporary suspense and deprived of medico protection. Please see your county secretary if you are in arrears.

March may be a bleak and dreary month but this March is sure to be a bright one for no matter what the weather may be it cannot dampen the bright cheer that will be in evidence by reason of the inauguration of Harding and Coolidge.

Make your reservations for rooms at Bay City now. The Wenonah Hotel will be our headquarters. Bay City will arrange to care for the comfort of every member, but get your reservations now.

Just run through our advertising pages before you lay this issue aside. These advertisers are your patrons and merit your support.

Correspondence

Detroit, Feb. 11, 1921.

Dr. Frederick C. Warnshuis,
Michigan State Medical Journal,
Grand Rapids, Michigan.

Dear Doctor:

Could you kindly give us some notice in regard to the Post-graduate work in progress at the Woman's Hospital, 443 E. Forest Ave., Detroit, Michigan.

Dr. James E. Davis is giving a course of 20 hour lectures in gynecological pathology as follows:

Female external genitalia	2 hours.
Uterus	3 hours.
Oviducts	2 hours.
Ovary	2 hours.
Peritoneum	1 hour.
Urinary system	3 hours.
Inflammation	3 hours.
Neoplasia	4 hours.

Following Dr. Davis's course Dr. Harry Schmidt will lecture to us upon Internal Medical subjects allied to obstetrics and gynecology. In another year we expect to amplify these courses very much.

Courses in obstetrics, gyenecology and surgical anatomy are being arranged for another year.

Any desired information about these courses which are open to any physician of good standing will be gladly furnished if you will write to Dr. C. Hollister Judd, 1229 David Whitney Bldg., Telephone Cherry 1120.

Truly yours,
C. Hollister Judd,
President of Medical Board.

Detroit, Feb. 9, 1921.

Dr. F. C. Warnshuis, Secretary-Editor:

In reply to the circular letter "County Secretaries' Letter No. 2" and "1," dated February and January, respectively.

Wish to say that I believe it would be a good thing to have a Secretaries' Meeting in connection with the Annual Meeting of the State Society in Bay City, May 24-26th. I for one would be quite willing to take part in any way that you may suggest to help in such meeting.

The February Journal has just come to hand—a day or so ago—but in informal conversation with many of the members, I find that a great many have taken an evening off to read it, and particularly the stenographic report of the Conference Meeting at Ann Arbor.

With regard to the Clinical Teams of the State. We seem to be pretty well supplied every Monday night so far as programs are concerned. Walter Manton is Chairman of the Program Committee and it might not be out of place to approach him directly on the subject. Harper Hospital is giving weekly Clinics, also Dr. James E. Davis and Dr. H. Schmitt are giving courses in Pathology and Internal Medicine at the Women's Hospital. So that we seem to be fairly well provided for in the way that the Clinical Teams of the State Society could function.

With regard to getting correct addresses of our Members. We have done about everything possible to notify each member of the necessity of sending his address direct to the State Society, as well as keeping us posted as to his whereabouts, and of his new street number.

With regard to the percent of members attending each meeting. That varies. Our quarters—that is the Auditorium of the W. C. M. S. will hold 400 persons. The membership numbers in the neighborhood of 1,050. We have a regular attendance of approximately 40 per cent. and consider this a very good attendance inasmuch as we are not aware of a larger percentage of any organization attending regularly.

Four Hundred Eight members paid their dues in full to the Society during the month of January. Comparing one year with another we consider this a pretty good showing.

In regard to the physicians and surgeons in Detroit and Wayne County who are not members. We are getting them in gradually; that is, where they are considered ethical. We have a method of investigation which is quite effective, so that not all who apply are admitted to membership.

You already have a list of the Delegates and Alternates to the State Meeting in May.

Since the war has ceased and the men are back in the harness, there is a marked enthusiasm in connection with the Medical Society. The pro-

gram has been varied by the introduction of two evenings during the past two months devoted to vaudeville of a very superior sort conducted by members of the Society, on which nights the Board of Censorship was bound, gagged and rendered ineffective. This particular evening of entertainment is taken care of by our Entertainment Committee composed of all-live members.

With very best wishes, and wishing always to co-operate with you, beg to remain,

Most cordially,
Wayne County Medical Society,
J. H. Dempster, Secretary.

Frederick C. Warnshuis, M.D.

Dear Doctor:

No Sir, not for publication, just to tell you what folks think way back here in the jack pines.

When they go out to make laws for the doctor or the farmer, Lord bless the beneficiary.

Every move for medical legislation ties a new hay wire around the physician.

The charlatan has ten times the privilege right in Grand Rapids that the regular physician enjoys.

None of the faddists have to pay out big money for antitoxin. They are not liable for defective work.

They get the velvet.

Let us have a law to furnish them antitoxin. There are plenty of good physicians soft enough to teach them how to use it.

And now for State Medicine. Divide up the territory to suit the politicians.

In fact we can dispense with the physician entirely. Make it a political job, instructions from Lansing.

If a man don't believe in State Medicine he is a socialist or maybe if that don't fetch him a bolshevist.

Of course socialism is too paternalistic. Self determination is a big word, but it should not apply to a citizen's right to choose a doctor, nor to a doctor's right to choose his line of treatment.

It is too bad the doctors—small ddd now—are not organized. Gee, what made all those fellows come down to Ann Arbor? Bet they wanted one of those ten thousand dollar jobs. No Sir, Got to go outside of Michigan to get men good enough to doctor rich folks for big fees. One could have said to Dr. Burton: "In this room are some of the best physicians in America, yet some of these able and skillful practitians have acquired their knowledge, their skill and their humane methods working upon poor patients."

"Learning the difference between the treatment of the rich and the treatment of the poor" ought to be an argument for the advocates of State Medicine, Or is it the beginning of it?

Any way Doctor Burton told you when it was train time.

Dr. Warnshuis, you are doing great work. I am proud of the Journal, and I am beginning to be proud of the Association.

R. H. W.

REPORT OF DELEGATES FROM THE WAYNE COUNTY MEDICAL SOCIETY TO A CONFERENCE AT ANN ARBOR.

To the Wayne County Medical Society:

The undersigned, as delegates from this society to attend a conference called by the medical faculty of the University of Michigan, beg to make the following report:

In response to an invitation extended to the medical profession of this state by the faculty of the Medical School of the University of Michigan, your delegates, together with a large number of physicians from various parts of the state, met with the faculty and the president of the university in the Michigan Union, Thursday, January 13, 1921.

The conference was called for the stated purpose of explaining to and discussing with representatives of the medical profession of Michigan, plans which had been formulated by the university for hospital construction and organization and for the teaching of medicine and surgery.

President Burton of the university presided, and in an address of some length presented and explained the general features of the proposed plan. In brief, this consisted in the adoption of the diagnostic-group plan of faculty organization and medical teaching, with full-time professorial appointees, having adequate salaries, who were not to be allowed to engage in the private practice of medicine. The University Hospital, now under construction, was to be carried forward and completed so as to provide ample accommodation for all necessary patients, its total capacity being somewhat indefinitely given as from 800 to 1,000 beds more or less. In this hospital proper provision was to be made for two classes of patients:

1. Those who paid nothing for medical or surgical services.

2. Those who paid to the Hospital for such services fees, more or less equal in amount to what they would have paid for the same service to physicians or surgeons in private practice.

This latter class of patients, and the income derived from them, was stated by the President, as essential not only to the teaching program, but also to the financial support of the Hospital. How many of these patients, who might properly be called "private," as distinguished from the first named class or "State" patients were necessary to the plan, was not stated, but there was no suggestion as to any intention of limiting their number.

A free discussion followed, in which physicians from various portions of the state as well as several of our own delegates took part. With one exception, and that a non-delegate, the opinions expressed agreed in utterly refusing to endorse any plan which provided for the care and treatment by the University of any patients who either paid for such treatment, or were properly able to pay for it.

Such portions of the program as related to a change or betterment of the methods of instruction in medicine now in use in the University, by which a higher standard of excellence was to

be secured, either for the faculty or the students, was generally approved, but the proposal to have the State of Michigan enter into the private practice of medicine and surgery through the doors of the university, was most definitely and emphatically disapproved of by the medical profession as represented at this conference.

Your delegates beg to offer the following resolution as part of this report:

The Wayne County Medical Society at its general meeting on January 17, 1921, resolved:

1. That any plan or intention on the part of the authorities of the University of Michigan to construct and use any part of any university hospital for the treatment of patients able to pay for medical or surgical services, meets with its entire disapproval.

2. That to charge patients in the University Hospitals or any other State hospital or institution, for medical or surgical services rendered to them by employees of the State, is a dangerous and vicious proposal and should meet with no approval from any social group in this commonwealth.

3. That it is the opinion of this society that a high standard of medical education can be secured and maintained in the University of Michigan both in its class rooms and its hospitals by means other than those that are now proposed by its faculty, and in such a way as to be to the advantage of both the medical profession and the community itself.

(Signed) J. B. Kennedy, Geo. E. Frothingham, R. L. Clark, Charles F. Kuhn, Max Ballin, James E. Davis, Angus McLean, Walter J. Wilson, Jr., J. H. Dempster, Frank B. Walker, Harold Wilson, E. H. Sichler, F. B. Tibbals, H. A. Luce—Delegates.

A LETTER RELATING TO CLOSED HOSPITALS.

The proposition of the closed hospital resolves itself into the discussion of the following factors:

1. Prostitution of a Public Institution in the interest of personal emolument.

2. The necessity of secrecy or isolation of the few for the purpose of furtherance of science or investigation.

3. The exclusion of the young professional man from the privileges of hospitalization of his patients, and denial of inspiration from association with the more experienced.

4. Whether the State Board of Registration or a self appointed Board of Censors shall constitute the Tribunal to pass on one's fitness to practice or not to practice medicine.

The majority of hospitals established for general care of the community's disabled, aside from purely municipal ones, have been built by private contributions, with the intent of the donors that such contributions would thereby best serve the public of the community. This service was intended as much for the citizen as for the physician. I question if there was any intent on the part of the contributors to provide an institution presided over by a clique of physicians whose purpose was to exclude citizens and physicians who failed to subject themselves to their jurisdiction.

Under the guise of advancing scientific medicine and the prevention of practice by men unskilled in the art of medicine the staffs of the closed hospitals propose to appoint themselves the arbiters of what does not constitute good practice. Who, may I ask, will censor the work of the hospital staff? Are they immune from errors of technic and good judgement? Richard Cabot of the Massachusetts General Hospital in Boston, Mass., in a published statement not long ago admitted that their records checked by autopsy examinations showed only 30 per cent. of correct diagnosis. I question if any worse record can be made by men not admitted to the staffs of the closed hospitals. Can the staff members of the closed hospitals prove by records that all the operations were justified by permanent cures? In the event patients desiring admissions are deprived of the service of their attending physician, why must they seek the advice and service of the staff physician? What is the object? With the leverage of staff appointment the patient is pried loose from his family physician and forced into the hands of some one appointed to the staff. For what? Science! No for money. Who designates the staff physicians as the ultra men of science. The same assumption that constitutes a Christian Science Healer. Faith in themselves that they are such.

There is no record in Historical medicine or proof in modern achievement that secrecy or work behind closed doors is a necessity in the furtherance of pure science. The great discoveries, have in the main been made by men who practiced in the open, not in the cloister. Many of these have come from the general practitioner, not the hospital man. McKenzie, Jenner, and Koch made their greatest investigations while still in general practice. The great minds of history were not developed in private but in free intercourse with the public.

Under the closed hospital regime the young graduate can treat his patients as long as they remain at home. Once they cross the threshold of the hospital, he is done; they become the "property" of the hospital staff. Will the fees be larger than those charged by the young graduate? Yes by a large majority. In whose interest? The patients? The young physician's? No; entirely in the financial interest of the hospital staff. Will the young physician benefit by observation of these super men and their operations? No; he will go back to the outskirt happy in the thought that he has been a good bird dog for the hospital physician. Will the hospital physician make any mistakes? If he does he will be protected by the closed system and his grave yard will not have his name plate at its entrance.

As a matter of record physicians are licensed by the state to practice medicine. The license is obtained by examination and a certified record of educational attendance in reputable schools and colleges over a period of seven years. In

some states eight years. The law provides for the safety of the public by well enforced statute. If eligible under this statute why should a self appointed board of Hospital appointees seek to supersede the board established by the state. If there be necessity in the latter than why not abolish the former. If properly licensed by the state board why allowed to prey on the public, outside the hospital and not in. It is far easier to get down to the hospital in a closed car at nine a. m., smoke a few cigarrettes in the coat room, tell a few stories, make rounds in about two hours and pick up a few hundred dollars from the cases treed by the poor old excluded general practitioner, than to get out and hunt the game themselves. I have no doubt these super men who aim at a dictatorship in medicine through the means of the closed hospital feel that the manual toil of general practice would coarsen their refined intellects and dull the fine tactile sense that has produced more mistakes and a finer conceit than anything in medicine.

There are some things it is true, that are best closed. One of these is the staff of the closed Hospital. It should be closed from physicians and patients, that they may no longer sicken at a subterfuge as apparent as it is weak in the principles of fairness, equality and justice.

Dr. N. L. Hoskins.

Deaths

Doctor C. A. Gottman was born in 1869 and died February 10, 1921. He graduated from the Medical Department of the University of Michigan in 1890 and has practiced his profession in Detroit for the past 30 years. Doctor Gottman was a 32nd degree Mason and a member of the Redford Lodge. Apart from his profession he was intensely interested in astronomy and psychology.

Doctor Albert A. Parisot was born in 1869 and died in Mt. Clemens on February 3, 1921, of heart disease. He had been in poor health for the past year. Doctor Parisot graduated from the Detroit College of Medicine in 1895. He was one of the best known figures in the public eye in Macomb County for a score of years. He was one of the founders of the Knights of Columbus in his district and was three times elected Mayor of Mt. Clemens. His last term expired in 1917.

Mrs. Jennie Henderson of Detroit, wife of Doctor William R. Henderson and mother of Doctor William E. and Doctor Harold Henderson, died January 20, 1921.

Dr. William Elliott died January 15th of heart disease at his home in Escanaba.

Dr. Elliott was born near Owen Sound, Ontario. Surviving are the widow, one son and one daughter.

The death of the following doctor, not a member of the Society, has been reported: Dr. L. K. Hunter, Baron Lake.

State News Notes

The following physicians are members of the Detroit Curling Club: Doctors J. D. Mathews, F. B. Tibbals, F. W. Robbins, Charles Kennedy, E. C. Watson, Dale M. King, Frank Walker, Roger Walker, W. H. Morley, H. W. Paggemeyer, Harold Wilson, W. D. Ford, Hermon Sanderson and Thomas Davies.

The Canadian Curlers have practically won all their matches with Scotch and English teams. Doctor F. W. Robbins, of the Detroit Curling Club, is skipping one of the Canadian rinks. Several years ago the Caledonian curlers visited Canada including stops in Detroit and Duluth.

During the last part of January, Doctor F. B. Tibbals, President of the Detroit Curling Club, took four rinks of curlers to Toronto, Brantford, and Montreal for friendly matches with the Canadians.

On January 31, 1921, a smoker and vaudeville under the direction of the Entertainment Committee was pulled off in the Wayne County Medical Bldg., Detroit. Most of the entertaining was done by the members themselves. Doctor E. P. Mills told a number of "Highland Park Stories" including his famous effort "The Telescope." Dr. Van Der Velpin played two numbers on his saxophone which was followed by Doctor Gilbert Anderson with his "Balloon" and other stories. Doctor B. H. Larsson led his "Floradora Sextette (½)" on his violin. Doctor G. K. Sipe appeared as a minstrel and kept the house laughing. His Frank Kelley story will cling to the minds of many for some time to come. After G. H. McMahon sang several songs, the Experience Clinic was conducted by Doctor L. J. Hirschman and Doctors B. R. Hoyt, Mooney, Schmidt, and J. B. Kennedy presented cases in the form of anecdotes of the past. The entertainment closed with the "Waynoscope" showing the production of the human voice. Between 300 and 400 were present.

Important plans are under way by Surgeon-General Ireland for the centralization of all schools of instruction of the Army Medical Corps. Two special service schools will be maintained with various subdivisions, one the Field Medical Service School at Carlisle Barracks, Pa., and the other the Army Medical School at Washington, D. C. The instruction at the Carlisle School will have for its object the ready adaption of the civilian practitioner to the life, work and customs of the army and will offer progressive courses covering all subjects from recruiting to the organization, functions and administration of medical units. The Army School at Washington will offer to commissioned graduates from the Carlisle School and to selected officers of the National Guard and Organized Reserve, what might be characterized as postgraduate courses in certain professional subjects in their application to military medicine. All clinical work will be conducted at the Walter Reed General Hospital. There will be established a school for nurses, school of pharmacy and a school for en-

listed specialists. A medical research laboratory and a school for flight surgeons will be maintained at Mitchel Field, Long Island, with the object of training special medical officers for duty at flying fields.

POST GRADUATE LECTURE WOMAN'S HOSPITAL, DETROIT, MICH.

By James E. Davis, A.M., M.D. Pathologist.

Wednesday January 19, 11-12 a. m. and Friday January 21, 11-12 a. m. Subject—Female external genitalia.

Wednesday and Friday Jan. 26, Jan. 28, and Feb. 2, 11-12 a. m. Subject—Uterus.

Hereafter every Wednesday and Friday from 11-12 a. m., until the following subjects are completed:

Female external genitalia	2 hours
Uterus	3 hours
Oviducts	2 hours
Peritoneum	1 hour
Urinary system	3 hours
Inflammation	3 hours
Neoplasia	4 hours

These courses are open to any member of the Wayne County Medical Society.

Dr. Harry Schmidt will give a course in Internal Medicine which will begin after Dr. Davis finishes.

For full information call Dr. C. Hollister Judd. Cherry 1120.

The Michigan Department of Health is trying to do its part in making Michigan first in Health. It issues its monthly bulletin to 13,000 readers, it distributes public health literature, it assists in the inspections of school children, it maintains laboratories for milk and water analyses, it conducts Wassermann tests for the service of health officers and physicians, it furnishes lecturers on public health topics, it assists in arranging "health weeks" for any community, it loans exhibits for health campaigns, it maintains traveling health clinics, it gives expert assistance in establishing baby clinics, it assists in establishing county nursing systems, it offers you the privilege of a loan library on public health subjects, it sends prenatal instruction letters, on request, to expectant mothers, it makes confirmatory laboratory diagnoses of all types, it offers treatment for venereal diseases in 11 city clinics, it sends material to health officers for the swabbing of children's throats, it uses six education moving picture films and 1000 health slides, it conducts investigations in stream and lake pollutions, it advises on water purification and sewage disposal, it keeps the 6,500 physicians and health officers informed of health conditions throughout the state, it distributes arsphenamine at cost, it hospitalizes infectious cases of venereal diseases, it aids communities in Schick testing school children, and it has corps of physician inspectors to aid communities in control of epidemics.

Lent D. Upson and Robert Goodrich of the Governmental Research Bureau, called on the coroners Doctors James Burgess and Doctor Jacob Rothacker the latter part of January to discuss the proposed bill for the reform of the coroners' office. The Wayne County Coroners told them that the coroner's office in Detroit under the present regime is run efficiently and economically and at a far less expense than in other cities of its size. Both Coroners favored the proposed home rule bill and the proposed change in handling the city and county business. If in carrying out these reforms a better way of conducting the coroner's office should be worked out, they would be heartily in favor it it. They feel that the new bill is designed to give more authority and political pull to an existing board. This board wants the power to name the medical examiners who under the proposed new law, will replace the coroners. They fail to see where this will benefit the public. Under the present law the coroners are elected directly by the people.

Compulsory training of high and normal school teachers in hygiene, diatetics and preventive medicine so that they could detect the presence of infectious diseases among school children is being urged by several Detroit physicians. "Health officer Vaughan of Detroit informs me that his nurses detected 8,000 case of infectious diseases among school children during the past year," said Doctor J. B. Kennedy. "The teachers should be trained to do this work so that cases would be discovered and measures taken before infection of others was possible." Doctor Angus McLean will aid Doctor Kennedy in bringing the matter to the attention of the various medical societies.

The will of Julia Frances Owen of Detroit provided for the following institutions: Home of the Friendless ($10,000), Women's Hospital ($10,000), Protestant Orphan Asylum ($10,000), Children's Free Hospital ($10,000), Girls Friendly Society ($35,000), Florence Crittenden Home ($5,000), St. Luke's Hospital ($5,000), and Grace Hospital ($5,000).

At the request of the Detroit Department of Health, the Council on February 15, 1921, ordered the placing on the city ballot for April 4th election of a proposal to bond the city for $3,000,000 to build a 1,000 bed General City Hospital on the city's vacant property just north of the Herman Kiefer Hospital. If the proposal has the people's approval, construction will start immediately. Plans for the building already have been drawn. These plans were paid for from the $25,000 appropriation made by the Council about a year ago. The Department of Health intends to run this institution as an "open hospital" that is, its services will be available to the patients of all reputable physicians whether they are members of the hospital staff or not. It will take both free and paying patients as do all general municipal hospitals.

Doctor Harold Wilson, President of the Wayne County Medical Society, has appointed Doctors G. E. Frothingham and H. A. Luce to membership on the Legislative Committee, now com-

posed of Doctors J. B. Kennedy (Chairman), F. B. Tibbals, and Angus McLean.

The program of the general meeting of the Wayne County Medical Society for February 21, 1921, was "Medicine and The State." Mr. W. G. Curtis, President of the National Casualty Company, spoke on "Menace of Health Insurance" and Mr. J. M. Eaton, Member of Association for Labor Legislation, on "The Medical Problem from the Standpoint of Industry." The First District Dental Society and the Detroit Retail Druggists Association were guests of the Wayne County Medical Society that evening.

The Council of Physicians and Surgeons of Ontario appoints yearly 2 examiners on surgery, 2 on medicine and preventive medicine, 2 on midwifery and diseases of women, and 2 homeopathic examiners. The passing mark in Ontario is 60 per cent. in all subjects while in Michigan it is a 75 per cent. average with no subject below 50 per cent.

The fees differ widely in Ontario and Michigan.

	Ont.	Mich.
Matriculation endorsement	$ 25.00	$00.00
Examination	75.00	25.00
Certificate (lithograph)	5.00	1.50
Reciprocity	100.00	50.00
Annual assessment	2.00	00.00
Matriculation certificate to other provinces or states	25.00	00.00
Certificate indicating registration and moral character	5.00	00.00
Endorsement certificate of license to other provinces or states	25.00	5.00

(Ontario has a number of other fees).

The number of physicians in Ontario in 1918 was 3192 and in Michigan 4598.

The Ontario Council members get $125 per meeting in additional to their actual expenses while the Michigan Medical Board are reimbursed for their traveling expenses and a certain portion of their hotel bills.

During the past year the Ontario Council collected in fees $40,305.67 and its expenses were $36,395.51, leaving a balance of $3,910.16. During the same time the Michigan Medical Board collected in fees $13,505.71 and its expenses were $7,670.94, leaving a balance for the year of $5,-834.77.

The program for the Annual Congress on Medical Education, Licensure, Hospitals and Public Health (March 7, 8, 9, 10, 1921) appeared the latter part of January. The following men will take part, Doctors Blumer of New Haven, Mc Clanahan of Omaha, Hamilton of Minneapolis, Pusey of Chicago, Frazier of Philadelphia, Lancaster of Boston, Phillips of New York, Lovett of Boston, Young of Baltimore, Williams of Baltimore, Vaughan of Ann Arbor, Jackson of Minneapolis, Erlanger of St. Louis, Edmunds of Ann Arbor, Ewing of New York, Wilson of Rochester, Minn., Pepper of Philadelphia, Emerson of Indianapolis, Cabot of Ann Arbor, Billings of Chicago, Strickler of Denver, Bierring of Des Moines, Arnold of Boston, Pinkham of Sacramento, Goldwater of New York, Rankin of Raleigh, S. C., Crumbine of Topeka, Warnshuis of Grand Rapids, Hatfield of New York, George E. Vincent of the Rockefeller Foundation, R. L. Wilbur, President of Leland Stanford University and others.

Henry F. Vaughan, Health Commissioner of Detroit, recently visited Grand Rapids to study how the under-nourished school children are helped in that city by Health Commissioner Slemons and the Grand Rapids Board of Health. He reports some remarkable results have been obtained. Dr. Vaughan was so thoroughly convinced that he has included in the annual budget of the Detroit Board of Health $250,000 for this kind of work in Detroit. If allowed by the Council, it will be used to build a "Preventorium" at Northville, to accomodate 100 children. An institution such as this is only for children inclined to tuberculosis. Children who are only slightly under weight will be handled through the nutritional clinics which the Board proposes to establish in the public schools. The full co-operation of the parents is necessary for the success of this work. To accomplish this purpose the nurses will be sent into the homes to see that this is done.

A pleasant surprise party was given by Mrs. Beaumont in honor of Dr. Brainerd of Brainerd Hospital here. The event was attended by about 30 physicians from Alma and surrounding towns, and a pleasant program was given after an elaborate banquet, as follows:

Dr. S. E. Gardiner of Mt. Pleasant, toastmaster.

Piano solo, Dr. C. E. DuBois.

"The Early Days of Our Practice," Dr. F. J. Graham. Dr. Graham was called away and not able to return in time to read his paper, which was much regretted by all.

Vocal solo, Dr. W. E. Barstow.

Recreation, Dr. J. N. Day.

Vocal solo, Dr. E. H. Foust.

"Friendship," Dr. R. B. Smith. Also presentation of gold watch from the medical fraternity.

About 50 guests were present at the affair, which was held in the beautifully decorated dining room at the hospital. Mrs. Barstow of St. Louis and Miss Evans of the Masonic Home here, sang during the serving of the banquet.

Dr. Brainerd is 69 years old, has practiced surgery and medicine for 40 years, 35 of them in Alma. He came here from Fenton in 1886.

He bought the present site of his hospital 26 years ago, and began the construction of the hospital and completed enough of it so it was opened 25 years ago. He did three-quarters of all the work on it himself. He has an able corps of assistants with him at the present time, and an average attendance of eight patients per day.

A public hearing on Senator Johnson's bill to tax closed hospitals, was held February 15, 1921, before the Public Health Committee of the State Senate of which Doctor Lemire is chairman. Among the Detroit physicians who attended the hearing were Doctors W. L. Babcock, Harold Wilson, J. E. Maunders, F. A. Kelly, C. C. McClelland, R. J. Palmer, George Duggan, E. Collins, J. L. Lyston, C. Darling, J. E. Peterson, Neil Bentley, S. H. Knight, R. Stevens, J. T.

Watkins of Grace Hospital, C. G. Jennings, J. W. Vaughan, G. E. Frothingham, S. Hamilton, P. J. Morse of Harper Hospital, G. E. Chene, and A. G. DeWitt of Providence Hospital. Doctor J. D. Bradley of Eaton Rapids, Doctor J. Dubois of Grand Rapids, Rev. Father Michael of Ann Arbor and D. W. Springer, Secretary of the Michigan State Hospital Association were present from the state. Doctor O. B. Frye of Grand Rapids asked for another hearing so that the other side of the case might be represented. The Wayne County Medical Society has gone on record as opposed to closed hospitals but to date no action has been taken on the Johnson bill.

On February 17, 1921, Doctor T. A. McGraw, Jr. read a paper before the Detroit Medical Club on the Relation of the Endocrine Glands to Undergrowth. The Doctor showed lantern slides of the following types of dwarfs:

1. Cretin Dwarf (hypothyroidism).
2. Infantilism-Lorain Type (hypopituitarism-anterior lobe).
3. Achondroplastic Dwarf.
4. Hypophyseal Dwarf with Froelich's syndrome (hypopituitarism—both lobes).
5. Progeria (senility) (Sclerosis of all of endocrine glands).
6. True Dwarf.

He also showed a case of gigantism (hyper pituitarism). He stated that treatment is more satisfactory in the early or borderline cases. The results of organ therapy are slow to appear taking at least three months.

The officers of the next Annual Congress on Medical Education, Licensure, Hospitals and Public Health to be held in Chicago March 7, 8, 9, 10, 1921, are as follows: Doctors A. D. Bevan, Chairman of Council on Medical Education and Hospitals of American Medical Association; V. C. Vaughan, Chairman of Council on Health and Public Instruction of the American Medical Association; William Pepper, President of the Association of American Medical Colleges; D. A. Strickler, President of the Federation of State Medical Boards; and Frank Billings, President of the American Conference on Hospital Sedvice.

A table which appears in the January 1921 Bulletin of the Michigan Department of Health shows the monthly number of reported cases of various contagious diseases for a number of years back. We have taken the liberty to roughly group them as follows: Pneumonia and small pox are more prevalent in January, February and March; scarlet fever in February, March and April; meningitis and measles in March, April and May; whooping cough in May, June and July; typhoid fever and poliomyelitis in August, September and October; and diphtheria in October, November and December.

During the past year the Library of the Wayne County Medical Society has been the recipient of gifts of books and journals from the Doctors C. D. Aaron, H. L. Berman, Carl Bonning, H. R. Carstens, Ray Connor, G. E. Frothingham, T. M. Hart, C. W. Hitchcock, A. D. Holmes, David Inglis, R. C. Jamieson, G. J. Korby, A. Lappner, T. A. McGraw, Jr., C. E. Simpson, W. C. Stevens, A. Thuner and A. Windsor. Sixty-six new books were purchased during the year by the Library Committee.

The following are a few of the physicians who have been appointed to the attending staff of the Highland Park Municipal Hospital which will open this spring: Chief of Staff, George R. Andrews; Executive Committee, D. M. Greene (Chairman), G. R. Andrews, L. E. Clark, S. C. Crowe, W. N. Braley; Department of Medicine, G. R. Andrews (Chief); Department of Surgery, D. M. Greene (Chief); Department of Ophthalmology, Otology, Rhino Laryngology, M. M. Wickware (Chief); and Department of Pathology (Not filled as yet).

The announcement was made February 11, 1921, that the Colonial Hotel at Mt. Clemens would be remodeled and opened in about three weeks as one of the country's leading sanitariums. 400 beds will be provided at the start and the most modern equipment for the practice of radium therapy, Nauheim and other mineral baths and psycho analysis will be provided. About 20 physicians from Detroit and the East will make up the staff.

During the month of February Doctor R. M. Olin, State Commissioner of Health, gave a series of lectures in Detroit under the auspices of the health department of the Detroit Federation of Women's Clubs. "Michigan First in Health" was the lecturer's subject. He spoke in the Bell Telephone Bldg., the Club House of the Detroit Federation of Women's Clubs, Northwestern High School and the Second Baptist Church.

Doctor Oscar Klotz, Professor of Pathology inz the University of Pittsburgh, has been appointed a representative of the International Health Board of the Rockefeller Foundation for work in medical research and education in Sao Paulo, Brazil. It is expected that Doctor Klotz will spend a number of years in Brazil during which time he will serve as director of a pathologic institute. He will be assisted by several Brazilian physicians who have received their training in the United States.

A Czechoslovakian Commission for the Study of Public Health Administration in the United States is making a tour of the principal medical centers of the country at the invitation of the Rockefeller Foundation under the guidance of Doctor C. W. Wells of the International Health Board. While in Chicago, the members of the Commission spent an entire morning at the headquarters of the American Medical Association.

In California there is an annual tax on physicians which is payable January 1st of each year. The penalty for the non payment after 60 days is automatic revocation of the certificate which requires $10.00 fee for reinstatement. On the

basis of this annual registration the licensing board prepares a directory of all who are practicing the healing art in the state.

A Citizens Meeting was held in the Ball Room of the Statler Hotel, Detroit on February 17, 1921. Doctor George E. McKean, Doctor John S. Hall (Dentist), W. S. Lister, Allan Campbell, E. T. Marschner and Garfield Nichols spoke on "Our Public Schools." These men are all candidates for the two vacancies on the Detroit Board of Education.

On February 12, 1921, Senator Johnson of the Michigan State Senate met with the representatives of the various Detroit Hospitals and some members of the medical profession. Doctor J. B. Kennedy presided. They discussed the pros and cons of Senator Johnson's bill to tax the closed hospitals.

Doctor Plinn F. Morse of Detroit is devoting the hours from two to four afternoons to Consultations and Diagnostic Medicine at 987 Jefferson Ave., East. Doctor Morse was formerly Professor of Pathology at the Detroit College of Medicine and Surgery. He is Pathologist to Harper Hospital and to the Detroit Receiving Hospital.

The midwinter annual meeting of the Middle Section of the American Laryngological, Rhinological and Otological Society was held in the Webster Hotel, Chicago on February 22, 1921. The following Michigan Physicians are members: Don M. Campbell of Detroit, R. B. Canfield of Ann Arbor, Ray Connor of Detroit, H. J. Hartz of Detroit, B. R. Shurly of Detroit, and Harold Wilson of Detroit.

The first regular meeting of the Academy of Surgery of Detroit was held in the Medical Building, Detroit, January 21, 1921. The society were guests of the President, Doctor Angus McLean at dinner. In the evening Doctor Max Ballin read a paper on "Traumatic Cirsoid Aneurysm of the Hand" and Doctor Charles Kennedy on "Repeated Gastric Hemorrhages."

On February 8, 1921, the Fellows of the Detroit Academy of Medicine listened to a paper by C. J. Marinus, M.Sc. on "Some Factors Influencing the Therapeutic Value of Corpus Luteum Preparations" and to a second paper by W. H. Morley, M.D. on "The Interstitial Gland—What It Is and Its Supposed Function." Both of these were well illustrated with lantern slides.

The Highland Park Municipal Hospital will have 120 beds when it opens this spring. There is room on the grounds to build two more units which would make the capacity of the hospital 360 beds. The heating plant has been built sufficient to take care of this expected growth. The hospital land and buildings have cost the City of Highland Park so far nearly $750,000.

Dental School Clinics are costing the City of Detroit about 17 cents a pupil. An examination of 2,000 children last December showed 96 per cent. had some dental defect while in a school which had been participating in dental clinics for several years, only 58 per cent. of dental defects were found.

Doctor T. C. Lyster of the Rockefeller Foundation has gone to Mexico to make some observations on the present epidemic of yellow fever and offer the assistance of the Foundation in a campaign for the eradication of the disease. The President of Mexico has accepted this offer.

Doctor K. T. (Mike) Knode, graduate of the Medical Department of the University of Michigan 1920, who started on the Varsity Base Ball Team and who later played on the St. Louis National Team, has announced that he has retired from the field of baseball and that he will limit his endeavors to the practice of medicine in Grand Rapids.

The Detroit Hebrew Hospital Association expects to break ground for their new hospital about June 1, 1921. The site on the corner of Antoine and Hendrie Ave. is all paid for. Doctor W. L. Babcock, Supt. of Grace Hospital who has looked over the plans, states that this hospital when finished, will be one of the most attractive and up-to-date institutions that this section of the country has ever seen.

The maximum prison sentence, six months, was imposed, February 16, 1921, on John Wolhocki, of Detroit, convicted before Judge Cotter of practicing medicine without a license. According to the complainant, Wolhocki treated him for a disease which he did not have and charged him $100 for the treatment of the same. Major John Roehl collected the evidence in this case.

The Detroit Department of Health is making life just as miserable as it can for the medical quacks and men practicing medicine without license in Detroit. Major Roehl in behalf of this department has been most successful in collecting and furnishing the Prosecuting Attorney's Office with the material necessary for conviction.

The Department of Health estimates the number of under-nourished school children in Detroit at 9,000 or more. Many of these children are bordering on disease as a result of their condition.

The Memorial Hospital in Owosso will be opened about May 1, 1921. It will be one of the most modern hospitals in the State. It will contain two large operating rooms, a first aid operating room and will have a capacity of 58 beds. A nurses' home will be built in the near future.

According to announcement made by W. Barclay Parsons, Chairman of the Board of Trustees of Columbia University, plans have been formulated for raising $10,000,000 to build and endow

a new medical school in connection with Columbia University, to supplement the present College of Physicians and Surgeons.

On Tuesday evening, January 25, 1921, Doctor Guy L. Kiefer gave a very illuminating talk before the Detroit Academy of Medicine on "Public Health and Other Interesting Legislation for 1921." A resolution was passed unanimously by the Detroit Academy of Medicine endorsing the Public Health Bills, presented by Doctor Kiefer.

On January 8, 1921, an unfortunate accident occurred in Toronto. .Two lady patients were given doses of diarsenol instead of neodiarsenol. They both died within 15 minutes after receiving the injection. The mistake was not recognized until after their death.

The annual meeting of the Detroit Tuberculosis Society was held the latter part of January 1921. Doctors H. M. Rich, B. R. Shurly and A. B. Wickham were elected to the Board of Directors. Doctor Rich is First Vice President and Doctor B. R. Shurly is Ass't. Treasurer.

On February 1, 1921, a dinner of 50 covers was held at the Hotel Harrington, Port Huron, in honor of Doctor T. E. DeGurse, Mayor of Marine City. On this occasion Doctor DeGurse was presented with a handsome silver loving cup by the citizens of Marine City.

On February 22, 1921, the Detroit Tuberculosis Sanitarium celebrated the Tenth Anniversary of its opening. The Board of Trustees sent out 3,000 invitations. Mrs. Kiefer, wife of Doctor Guy L. Kiefer, was Chairman of the Decoration Committee for this event.

St. Mary's Hospital of Detroit is one of the oldest hospitals in Michigan, having been organized in 1845. Recently new wings containing operating rooms laboratories and 200 extra beds have been completed. The hospital is opened to every reputable physician of the State.

Beginning October 15, 1920, the Attending Staff of Grace Hospital, Detroit, began a schedule of lectures to the Internes of that hospital. There will be 37 of these, the last being given May 27, 1921. The subjects seem to be very well chosen with a practical intent.

February 11, 1921, John Wolhocki of Detroit was found guilty in Judge Cotter's Court by a jury of practicing medicine without a license. Wolhocki contended he was a general office man for Doctor Witherell (730 E. Forest Ave.) He was remanded for sentence.

The February General Meeting of the Wayne County Medical Society was a two paper affair. The first one, by Doctor J. H. Dempster, was on The Physiological Action of and Therapeutic Indications for the X-Ray, and the second, by Doctor W. R. Clinton, on "The Treatment with Radium."

The January 29, 1921 issue of the Detroit Saturday Night contains nearly a full page article on "Public Health Will Suffer If State Curbs Doctors' Freedom," by Doctor Harold Wilson, President of the Wayne County Medical Society.

On January 28, 1921 Doctor Richard R. Smith of Grand Rapids was elected Surgeon of the Michigan Commandery of the Military Order of Foreign Wars of the United States at their meeting held at the Hotel Statler, Detroit.

A dance was given on February 17, 1921 at the Hotel Statler by the Lenox Patriotic Club for the benefit of the invalided soldiers and sailors now convalescing at the Marine Hospital and at the Detroit Tuberculosis Sanitarium.

The Highland Park Physicians Society which meets bi-monthly, has a membership of about 60. Doctor D. D. Stone is President, Doctor Wallace is Vice-President, and Doctor Beardslee is Secretary-Treasurer.

Upon the recommendation of its Board of Trustees, the Wayne County Medical Society on February 7, 1921 voted an assessment of $1.50 per member to cover the increased dues ($1.50) of the Michigan State Medical Society.

On February 12, 1921, the Board of Regents of the University of Michigan voted to raise the fees of the non-residents in the medical department from $35 to $200 and in the dental department from $25 to $200.

Doctor W. J. Seymour is President and Doctor H. A. Reye is Secretary of the Medical Staff of St. Mary's Hospital for the coming year. The Executive Committee is Doctors A. W. Blain, John Lee and L. L. Zimmer.

The Ohio State Medical Board elected the following officers for 1921: Doctors Charles E. Sawyer (President), Lee Humphrey (Vice-President), S. M. Sherman (Treasurer) and H. M. Platter (Secretary).

The Detroit Ophthalmological and Otological Club held its monthly dinner, February 2, 1921, at the Medical Building, Detroit. Following the dinner Doctor L. E. Grant presented a paper on the Ear in Ex Service Men.

Doctor W. H. Sawyer of Hillsdale has been renominated by the Republican Party for Regent of the University of Michigan. The Doctor has already served two terms.

Doctor and Mrs. Matthew Brady of Detroit left February 7, 1921, for an extend trip through the South. They will stop among other places at Virginia Hot Springs and New Orleans.

On February 24, 1921, following the Banquet of the American Congress on Internal Medicine, the Fifth Annual Convention of the American College of Physicians was held.

Doctor S. D. Beebe of Sparta has been appointed a member of the Wisconsin State Board of Medical Examiners to serve the unexpired term of Doctor H. W. Abraham, deceased.

The St. Clair Country Club elected Doctor R. D. Morand of Windsor Vice-President and Doctor W. G. Paterson of Detroit a Director at a recent meeting.

Dr. W. H. Sawyer of Hillsdale was endorsed for renomination for Regent of the University of Michigan by the Eaton and Bay County Republicans February 7, 1921.

Doctors George A. Tolman and Robert Foster of Highland Park attended some surgical clinics in Rochester, Minn., and Chicago during the latter part of February.

The Detroit Dermalotogical Association has been organized with Dr. Andrew P. Biddle and Dr. C. A. Doty as temporary President and Secretary.

Drs. O. L. Ricker, S. C. Moore, J. F. Gruber, P. W. Bloxsom, M. Doudna and F. J. Henry of Cadillac have formed a group association.

Doctor J. L. Henderson is a candidate of the Liberal Party for Trustee of the City of Hamtramck.

Mrs. Carstens, widow of Doctor J. Henry Carstens of Detroit, and her daughter, Miss Mildred Carstens, are spending the winter in California.

The members of the Samaritan Hospital Auxiliary Association of Detroit gave their Ninth Annual Ball at the Statler Hotel on February 7, 1921.

Doctor A. W. George was elected President of the Detroit Rifle and Revolver Club at their annual meeting in January.

James Alan Ridenour, son of Doctor and Mrs. Ridenour of Detroit, was born December 26, 1920.

Twin sons were born to Doctor and Mrs. Stuart Wilson of Detroit, January 29, 1920.

Doctor J. B. Kennedy was Toastmaster at the annual banquet of the Detroit Burns Club, held at the Hotel Tuller on January 25, 1921.

Doctor and Mrs. E. T. Tappey of Detroit left for Bermuda the last part of January.

The Fifth Annual Meeting of the American Congress on International Medicine was held in Baltimore, February 21-26, 1921.

Doctor E. R. Beckworth resigned as prison physician from the Ionia Reformatory, February 9, 1921.

Doctor H. C. Begle was re-elected President of the Detroit Congregational Union at the annual meeting, February 4, 1921.

The Detroit Department of Health expects to open their new Municipal Tuberculosis Hospital at Northville not later than July 1921.

Doctor and Mrs. George Potter of Detroit left the latter part of January for California. They will return about May first.

Dr. A. P. Jacoby has been appointed Chief of the Psychopathic Clinic in the Detroit Recorders Court.

Dr. G. E. Arnold has been appointed Health Officer of Albion. His predecessor resigned because of meager salary paid.

Dr. Herman Ostrander has been elected a member of the National Committee for Mental Hygiene.

During the month of February Doctor and Mrs. T. A. McGraw, Jr., of Detroit spent two weeks at Ormond Beech, Florida.

Detroit Medical Journal has discontinued publication.

Doctor A. N. Collins returned from California to Detroit the first part of February.

Dr. M. M. Hansen of Belding has moved to Sheridan.

COUNTY SOCIETY NEWS

It is the Editor's desire to have this department of the Journal contain the report of every meeting that is held by a Local Society. Secretaries are urged to send in these reports promptly

ACADEMY OF SURGERY OF DETROIT.

The Academy of Surgery of Detroit was formally organized at a meeting held at the Detroit Athletic Club, on December 7, 1920. The following officers were elected:

President—Angus McLean.

Vice-Presidents—H. W. Hewitt and Joseph Andries.

Secretary-Treasurer, Ira G. Downer.

The first regular meeting was held at the

Wayne County Medical Building on January 21, 1921, and the following program rendered: TRAUMATIC CIRSOID ANEURYISM OF THE HAND, Max Ballin. REPEATED GASTRIC HEMORRHAGE, Case report, Charles Kennedy.

The Society will be limited to general, orthopedic, and gynecological surgeons. The Society will hold regular monthly meetings. The membership is divided into three classes, Active, associate and honorary members. Active members are residents of Detroit, Associate members are residents of Michigan, Northern Ohio and Indiana, and Ontario. The following Honorary members have been elected: Theodore McGraw, Sr., Detroit; John Wishart, London, Ontario; C. B. DeNancrede, Ann Arbor, and H. R. Casgrain, Windsor, Ontario. Active membership is restricted to forty.

Ira G. Towner, Secretary.

BAY COUNTY.

A regular meeting of the Bay County Medical Society was held Monday evening, Jan. 10, at the Elk's Temple.

Dr. McLurg was unable to report from the Council meeting on account of his enforced absence from the city.

Dr. Chas. Baker gave a detailed and interesting report of the University Conference at Ann Arbor and the information enthusiastically welcomed.

The paper of the evening was read by Dr. Chas. L. Hess, of the local Society, on "Laboratory Methods as an Aid in Diagnoses."

The evening's business was routine and consisted mainly of committee appointments, President McDowell, announcing the committees which would have charge of the State Meeting.

The next meeting, Feb. 14, 1921, will be held at the Wenonah Hotel and will be addressed by Dr. F. C. Warnshuis, our State Secretary-Editor, of Grand Rapids, and Dr. R. M. Olin, State Commissioner of Health, Lansing.

The regular meeting of the Bay County Medical Society was held Monday evening, Feb. 14, at the Wenonah Hotel. The meeting, called to order at 8:15 was preceded by a banquet at 6:30.

The speakers of the evening were Dr. J. W. Deacon, State Epidemologist, and our State Secretary, Dr. F. C. Warnshuis.

Dr. Deacon gave an interesting account of the Ionia prison conditions which he described as "filthy—physically, mentally and morally." He explained the three legislative requests of the State Health Department, viz.

1. Transference of Department of Vital Statistics from the State Department to the Health Department.
2. The issuance of free antitoxins by the State.
3. The adoption of the "County Health Officer" plan.

The latter plan being essentially the replacing of some 700 heterogeneous health officers with about 50 trained physicians as full-time County officers.

Dr. Deacon then went into the question of the State Health clinics, explaining their intended function.

Dr. Warnshuis decried the "cuet and clinic" evils of medicine but urged the idea of diagnostic or consultation clinics. His reference to an apparent lethargy on the part of the legitimate profession to such ideas as the cuets and clinics was very timely.

He gave many of the society members a clearer vision of the State Society's activities, especially those of the legislative committee.

Dr. Warnshuis then outlined in detail the plans of the State Meeting for May.

The President appointed the following Committees:

Censors—Drs. Gallagher, Hess and Foster.

Program Committee—Drs. Slattery, Ch., Zaramba, Stewart, Dumond, Foster.

Reception Committee—Drs. Urmston, Ch., with whole Society as members.

Entertainment Committee—Drs. Perkins, Ch., Hauxhurst, Gallagher, J. W. Gustin, F. S. Baird, Crance.

Ladies' Entertainment Committee—Drs. Williams, Ch., Ely, Tupper with the wives of the Society's members.

Exhibit Committee—Drs. Loud, Ch., Stone, Trumble, Huckins.

Accomodations Committee—Drs. Dumond, Ch., Slattery, Foster, Zaremba, Stewart.

Arrangements Committee—Drs. Grosjean, Ch., Baker, T. A. Baird.

Printing Committee—Drs. S. L. Ballard, Ch., McEwan, Bergstrom, Lawrence.

The Society went on record as favoring:

1. The State Health Clinics.
2. The Legislative bills proposed by the State Health Department, viz.,
   (a) Free antitoxin.
   (b) County Health Officer plan.

After accepting an invitation of the Saginaw Medical Society to attend its meeting, Feb. 24, to hear Dr. Parnall, Supt. University Hospital, the meeting adjourned.

L. Fernald Foster, Sec'y.

CALHOUN COUNTY

The first monthly meeting of the Calhoun County Medical Society for 1921 was called to order in the Post Tavern dining room, Tuesday, January 4th, at 7:30 p. m., following a dinner.

The President announced that without objection the minutes of the last meeting, as published in the Bulletin, would be approved, and they were approved.

The Secretary read a communication from the University of Michigan Hospital, inviting a conference of representatives of the various medical societies and the profession on January 13th at Ann Arbor.

Moved by Dr. Stone that the Chair appoint a committee of two or three to attend the meeting in Ann Arbor. Supported and carried. It was also urged by several that as many members as possible attend this meeting.

The Secretary read a communication from the Exchange Club inviting this society to appoint a committee to confer with a similar committee from the Exchange Club and committees from various other organizations to study the advis-

ability of re-establishing in Battle Creek a Y. M. C. A, and if found feasible, to consider means.

Moved by Dr. Eggleston that the Chair appoint a committee of three to comply with the purpose of communication from the Exchange Club. Moved and carried.

Secretary read a bill from Phoenix Printing Co. for $7.85 for postal cards and $14.85 for 500 copies of The Bulletin; total $22.70.

Moved by Dr. Kimball that this account be paid. Supported and carried.

The Secretary read application for membership from Dr. A. W. Wooley of Battle Creek Sanitarium; this being the second reading.

Moved by Dr. Kimball that the rules be suspended and that the Secretary cast unanimous ballot of the members present for Dr. Wooley. Supported and carried. The Secretary cast the ballot and the President declared Dr. Wooley elected a member.

President Shipp asked Dr. Stone, chairman of the program committee, to take charge of the speakers. Dr. Stone made a short announcement of the year's program promising a very interesting one throughout the year. He stated that the speakers of the evening would discuss "State Medicine," Compulsory Health Insurance," and "Legislative Control of Fees." Dr. Angus McLean, President of Michigan State Medical Society, was called upon and gave a very interesting address. This was followed by Dr. G. B. Kennedy, chairman of the Legislative Committee of the Wayne County Medical Society, who also spoke very forcibly and feelingly on the above subjects. Both speakers invited questions and extensive discussion.

They brought out the fact that the Compulsory Health Insurance, started in Germany in 1883, and has succeeded not only in pauperizing the profession, but suspending the independence of the people, and the progressof the profession.

The discussion was opened by Dr. Toles of Lansing, followed by Drs. Crane, Kalamazoo, and Robinson, of Jackson.

Moved by Dr. Gorsline that the Calhoun County Medical Society as a body, and individually, go on record as opposed to the proposed legislation; also that a legislative committee of three be appointed by the Chair, and that the Society give its moral and financial support to the opposition to this legislation. This motion with the amendment as suggested by Dr. Kimball, and in its final form as above seconded and carried unanimously.

The discussion was continued by Drs. A. M. Hume of Owosso; G. S. Hafford, E. L. Eggleston, H. B. Knapp, R. M. Gubbins, R. F. Wafer, R. D. Sleight, R. E. Balch of Kalamazoo; Thomas Zelinsky, C. E. Boys of Kalamazoo; R. C. Stone.

Meeting adjourned. Attendance 71.

Wilfrid Haughey, Secretary.

GENESEE COUNTY.

The clinical section of the Genesee County Medical Society met January 28, 1921. Dr. T. S. Conover read a valuable paper on "Common Opthalmic Mistakes." Dr. J. G. R. Manwaring demonstrated the proper method of using Tarnier's Axis Traction Forceps. Dr. W. H. Marshall reported a case of Angina Pectoris and demonstrated a specimen showing Chronic Aortitis and Coronary Sclerosis.

At the regular meeting on Feb. 2, it was decided that this Society have a committee "to study and to report from time to time on the social tendencies in Medicine." One of the functions of this committee will be to become acquainted with legislation affecting our profession. Drs. H. A. Stewart, J. G. R. Manwaring and C. H. O'Neil were appointed for this purpose. Mr. A. McArthur, an entertainer, of Chicago was introduced and recited several poems of Eugene Field and J. Whitcomb Riley. Dr. V. D. Lespinasse, Prof. of Urology in the N. W. Medical School, Chicago, gave a splendid lecture, illustrated by lantern slides on "The Diagnosis of Urological Conditions." Of particular interest was his description of the methods of treating sterility in the male.

W. H. Marshall, Sec'y.

GRAND TRAVERSE-LEELANAU COUNTY.

The Grand Traverse-Leelanau County Medical Society met at a special meeting January 30, 1921, called by President H. B. Kyselka.

The following members being present: Drs. Thirlby, Swartz, Holdsworth, Lawton, Holliday, Tripp, Wilhelm, Kyselka, Rowley, Sladek, Gauntlett, Swanton, Minor.

Dr. E. L. Thirlby, who had just returned from Ann Arbor explained President Burton's plan for the new University Hospital and for Medical Education for the State of Michigan. All members participated in the discussion which followed.

It was moved that President Burton's plan for the new University Hospital and for Medical Education for the State of Michigan be endorsed by the Grand Traverse-Leelanau County Medical Society. Seconded. Carried unanimously.

Motion to adjourn. Carried.

Regular meeting Grand Traverse-Leelanau County Medical Society held February 2, 1921, at Dr. Lawton's office; the following members being present: Drs. Kyselka, Swanton, Lawton, Rowley, Gauntlett, Holliday, Sladek, Wilhelm, Thirlby, and Minor.

Minutes of the last regular and special meetings read and approved.

Considerable discussion took place relative to the present capacity of our General Hospital, and to the importance of insisting upon the necessary hospitalization of patients, where it is obvious that better work can be done by both the internist and the surgeon with more uniform and satisfactory results.

Motion to adjourn. Carried.

E. F. Sladek, Sec'y.

JACKSON COUNTY.

At a recent meeting of the Jackson County Medical Society the following officers for the year 1921 were elected:

President—Dr. E. S. Peterson, Jackson.

Vice-President—Dr. H. A. Brown, Jackson.

Treasurer—Dr. L. J. Harris, Jackson.
Secretary—Dr. T. E. Hackett, Jackson.

The Society meets the second Tuesday of each month at the W. A. Foote Memorial Hospital for a lunch followed by a clinic or a paper by an out of town speaker. The attendance at the two meetings have averaged 40 each.

The last regular meeting was held Feb. 8, 1921, and the membership enjoyed a most instructive clinic on "Diseases of the Skin," by Udo J. Wile, of Ann Arbor.

The Society has erected a memorial tablet for Dr. James A. Mc Zuillan, who was killed in action during the world war, Oct. 26, 1918. It is to be placed in the lobby of the Foote Memorial Hospital. Sunday, February 27, 1921, has been chosen as the day for unveiling the tablet. The address of the day will be given by Dr. Angus McLean of Detroit. The memorial will be public and will be held in the Elks Temple.

T. E. Hackett, Sec'y.

LENAWEE COUNTY.

I am enclosing a list of members of the Lenawee County Medical Society who have paid dues to date, together with check covering the same. Our new officers for 1921 are as follows:

President—Dr. C. H. Westgater, Weston.
Vice-Pres.—Dr. T. C. Krumling, Blisfield.
Secretary-Treas.—Dr. O. N. Rice, Adrian.

I was also instructed by the Society to ask you for a team on Fractures and Emergency Surgery and also one on Cardian and Renal Disease to come to Adrian some time during the year. I trust you will be able to arrange to that effect.

O. N. Rice, Secretary.

MUSKEGON COUNTY.

Muskegon County Medical Society met at Occidental Hotel, January 28, 1921, with President Cramer presiding. Following the banquet, Attorney Galpin and Wm. Jeannott appeared before the Society and asked that the Society consider the proposition of equipping one of the operating rooms at the new Mercer Hospital. On motion of Dr. A. P. Poppen, the following committee was appointed by the presiding officer to report at the next meeting: Dr. Geo. LeFevre, Dr. F. A. Garber, Dr. C. J. Durham, Dr. A. A. Smith, and Dr. E. S. Thornton.

Mr. Hokenga representing the American Legion addressed the society asking that all cases of illness among ex-service men be reported to American Legion headquarters. Approved.

Dr. Geo. L. LeFevre then gave a report of the Ann Arbor meeting following which Dr. C. C. Slemons, City Health Officer of Grand Rapids, discussed "Pending Legislation that Concerns the Doctor," namely.

1. A bill to transfer Vital Statistics from the office of Secretary of State to the State Department of Health.
2. Free distribution of antitoxin in State of Michigan, the State to ultimately manufacture their own antitoxin.
3. Appointment of County Health Officers.

After a discussion by Drs. Marshall, Addison, R. J. Harrington, Garber, and Jackson, on motion of Dr. Garber, the society voted in favor of the bills.

Dr. Durham moved that the president select two members of the society to discuss Botulinus poisoning at a meeting in the near future. Drs. Keilin and Addison selected.

A communication from the Secretary of Oceana County Medical Society, asking Muskegon County to arrange for one of the state teams to appear in Muskegon some time after May 1, 1921, at which their County Society would attend the meeting, sharing the expense. Approved and filed.

Thirty-two members were present.

Meeting adjourned.

E. S. Thornton, Secretary.

NEWAYGO COUNTY.

The annual meeting of the Newaygo County Medical Society was held at the office of the president Dr. J. C. Peltier, in Newaygo, Feb. 8, 1921. After the minutes of the last regular meeting, in September, the Society proceeded to the election of officers for the ensuing year with the following result:

President—P. T. Waters, White Cloud.
Vice-Pres.—Chas. Long, Fremont.
Secretary-Treas.—W. H. Barnum, Fremont.
Medical Defense Com.—N. DeHaas, Fremont.
Delegate to State Society—Willis Geerling, Fremont.
Alternate—C. B. Long, Fremont.

No further business appearing the meeting was then adjourned.

W. H. Barnum, Secretary.

OAKLAND COUNTY.

The annual business meeting of the Oakland County Medical Society was held at the Board of Commerce, Pontiac, Mich., Dec. 2, 1920, following a banquet at the same place.

The following officers were elected for the ensuing year:

President—H. A. Sibley, Pontiac.
Vice-President—F. A. Ulmer, Pontiac.
Secretary—A. V. Murtha, Pontiac.

The election of a Treasurer and the directors was postponed until certain changes in the by-laws providing for a separate office of treasurer could be adopted.

Dr. W. W. Wier, Royal Oak; Dr. Geo. Limenton, Pontiac, and Dr. B. C. Bradshaw, Royal Oak, were elected to membership. This made a gain of eighteen new members for the year, bringing the total to sixty-eight.

A special committee to arrange a schedule of fees with the poor commission and County Board of Auditors reported a satisfactory arrangement and the Society went on record as being opposed to any member accepting a contract to do work for less than the current fees.

The meeting was adjourned until such time as the Board of Directors saw fit to finish the business of the meeting.

This second meeting was held Feb. 1, 1921, at

the Board of Commerce, Pontiac, Mich. At this time the following additional officers were elected:

Treasurer—R. H. Baker, Pontiac.

Directors—D. G. Castill, Pontiac; Frederick Baker, Pontiac; Dr. Raynole, Birmingham.

State Delegate—R. H. Baker.

Alternate—Dr. Ferguson, Pontiac.

Drs. Lameraux, South Lyons and Keller, Royal Oak, were elected to membership.

City Manager Brower of Pontiac met with the Society to discuss a program for City Health, Sanitation and management of the hospital, and the balance of the evening was devoted to this work. The scope of work of the Health Department under Dr. Narfie has been considerably increased and now includes several free clinics under the charge of local physicians. Under the present efficient management and with the evident co-operation of the city manager we hope to have a health department that ranks among the first of the State.

A. O. Muntha, Secretary.

OTTAWA COUNTY.

Enclosed remittance $70.00 on account membership dues to date, as per statement.

Ottawa County Medical Society is in good shape. Our membership list includes every eligible physician in the county, but one, and we are educating some of the remaining nine men who are not eligible, to become so.

Our meetings have been well attended, and the members are showing a more lively interest in the Society, and in things medical than has been the case for years past.

S. Leenhout, Secretary.

TUSCOLA COUNTY.

Regular meeting of Tuscola County Medical Society held at Cass City, Mich., Dec. 31, 1920, at Pleasant Home Hospital. Meeting called to order by Pres. Bishop.

Dr. Barrett of Detroit gave an interesting paper on Thyroids and Their Treatment. Discussed by Dr. Seeley, Dr. McCoy, Dr. Handy and Dr. Johnson.

Moved and supported that we as a Society oppose the Health Insurance and County Health Officer proposed legislation. Carried.

Moved and supported that we adjourn. Carried.

S. B. Young, Secretary P. T.

Tuscola County Medical Society met at 3 p. m. We had with us Team No. 12, consisting of Dr. Randal, Dr. Manwaring, Dr. Treat, Dr. Cliff from Flint. These several physicians covered their different subjects in the line of fractures in a very instructive way and it was the general opinion of physicians present that the time was well spent in this meeting and our secretary was instructed to secure more of these teams if possible.

H. A. Barham, Secretary.

TRI-COUNTY.

At the annual meeting of the Tri-County Medical Society held Feb. 3, 1921, the following officers were elected:

President—Dr. C. E. Miller, Cadillac.

Vice-President—Dr. J. F. Doudna, Lake City.

Sec. Vice-President—Dr. Fairbanks, Luther.

Sec.-Treas.—Dr. W. Joe Smith, Cadillac.

Delegate to State Convention—Dr. Ricker, Cadillac.

Alternate to State Convention—Dr. W. Joe Smith, Cadillac.

Board of Directors—
Dr. D. Ralston, Cadillac.
Dr. T. Y. Kimball, Manton.
Dr. W. Joe Smith, Cadillac.

Program Committee—
Dr. W. Joe Smith, Cadillac.
Dr. S. C. Moore, Cadillac.
Dr. O. L. Ricker, Cadillac.

Finance Committee—
Dr. J. M. Wardell, Cadillac.
Dr. S. C. Moore, Cadillac.
Dr. C. L. Ricker, Cadillac.

Medico-Legal Committee—
Dr. John Gruber, Cadillac.

Contract Committee—
Dr. Wardell, Cadillac.
Dr. G. D. Miller, Cadillac.
Dr. S. C. Moore, Cadillac.

W. Joe Smith, Sec'y.

WAYNE COUNTY.

On January 24, 1921, Doctor George Crile of Cleveland read a paper before the Surgical Section of the Wayne County Medical Society on "The Role of the Liver in Disease." It was illustrated with a number of stereopticans. Doctor Crile advanced the theory that the human cell is an electric battery and that the driving force of the human body is electricity. Sleep is a recharging of the battery and wakefulness is the discharge of life's ammeter. He developed this theory but he left to future scientists the proving of it. By Proceeding on it, he has greatly reduced the operative mortality. He has accomplished this by the properly supplying the body cells with water and oxidization. This theory was advanced in his explanation of the relation between the brain and the liver. He does not believe that the function of the liver has yet been properly understood. The removal of this organ or the tieing it off in animals results in death within 4 to 12 hours. There is something in the liver that furnishes oxidization for the brain. An electric thermometer, which indicates a variation of 1-1000 of a degree, shows that the temperature of the brain begins to drop as soon as the knot is tied and continues to fall until death occurs. It appears to be the electric energy of the brain which drives the muscle cells of the body. He closed his paper by telling how necessary it is in some cases to prepare the patient properly before operating. This he does by giving the body 2,000 to 6,000 CC of water, by transfusing the patient or by a short course of digitalis as the case may be. Doctors Angus McLan, Dewitt, C. G. Jennings, Ives, Mac Millan, and J. W. Vaughan discussed the paper.

SURGICAL TREATMENT OF EXOPTHALMIC GOITRE—CONCLUSIONS.

1. Hyperthyroidism occurs with both hyperplasia and with adenoma of the thyroid gland.
2. Mild degrees of hyperplasia may improve under rest treatment. Otherwise operation is indicated.
3. Adenomata are always surgical to obviate the potential possibilities of subsequent toxity, malignancy or obstruction.
4. While laboratory methods are of inestimable assistance, clinical judgment based on experience renders the final diagnosis and selects the proper operative procedure.
5. The proof of the value of the surgical treatment of exophthalmic goitre must be estimated in terms of ultimate results.
6. The mortality from surgery is below any other form of treatment and cures are obtained in three-quarters of the more severe types.
7. Present excellent result are due to care in preparation and proper selection of the type of operation suitable for the case.
8. Future improvements will be due to earlier recognition and earlier operation.

(The Grace Hospital Bulletin, January, 1921—H. K. Shawan).

THE PSYCHOLOGICAL EXAMINATION OF CONSCIENTIOUS OBJECTORS.

The data used were taken from the records of about 1000 objectors from some twenty camps. While these represent not quite half of the total number of objectors in the army, the writer feels that they are a fair sampling. In intelligence their average is above that of the white draft of the army as a whole. 46.5 per cent. of objectors grade above C on the army test, while only 27.3 per cent of the army as a whole show a grade above C. 28.6 per cent of objectors are below C, while the army as a whole shows 47.9 per cent below. The ratio of the A and B men of the army as a whole to the A and B men of the objectors is 1:2. About half of 1060 objectors were of the Mennonite faith. The Friends, Brethren, Dunkards, International Bible Students and Israelities of the House of David constitute about 25 per cent. Of 958 cases, 90 per cent object on religious grounds, 5 per cent on social, 3 per cent on political, and 2 per cent on ethical grounds. Examinations were given by a psychologists in an effort to determine: (1) the objectors intelligence and mental soundness; (2) his educational and occupational history; (3) his religious experiences, knowledge of his church, creed, etc.; (4) his moral habits and social outlook. As a result three types stand out clearly. First, the religious-literalist type. This includes most of the Mennonites, Dunkards and many of the obscure denominations. Their objections are based on an appeal to the Bible, church and creed. Second, the religious-idealist type. Contrary to the first group, these are men with too much rather than too little social vision and with an unwillingness to sacrifice their ideals to expediency. This is the type usually found the disciplinary barracks. Third, the Socialist type—educated, intelligent, with a patriotism that recognises no "national" limits. About 75 per cent fall into the first class, while the second and third types constitute about 25 per cent.—Mark A. May. American Journal of Psychology, XXXI-2. April, 1920.

A nation-wide save your sight campaign is to be conducted by the recently organized EYE SIGHT CONSERVATION COUNCIL to acquaint the public with the importance of eye care and to urge the universal eye examinations of school children, workers in industry and clerks in stores and offices.

Special literature will be sent to teachers, employers and those especially interested in the advancement of efficiency and welfare in industry. Charts and posters are to be placed in school rooms and factories visualizing eye care, depicting the advantages of correcting ocular defects, and warning against eye strain and its atteanding evils.

The Eye Sight Conservation Council is a membership organization. The Directors and Councillors are professional men representing various organizations devoted to health, welfare, education, science and industrial betterment.

The following are the officers—

President—L. W. Wallace, New York, N. Y. who is President of the American Society of Industrial Engineers and recently elected an officer in the newly formed Federated American Engineering Societies of which Herbert Hoover is President.

Vice-President—Cassius D. Wescott, M.D., Chicago, Ill. Chairman of Committee on Conservation of Vision of the Council of Health and Public Instruction of the American Medical Association.

The other directors are—

R. C. Augustine, Decatur, Ill. President of the American Optometric Association.

Bailey B. Burritt, New York City, General-Director New York Association for Improving the Condition of the Poor.

R. M. Little, New York City, Director of the Safety Institute of America—member of the Executive Committee of the National Safety Council.

The personnel of the Board of Councillors is to be carefully selected and so far but few have been chosen, these being:

Dr. Thos. D. Wood, Teachers' College, Columbia University. Prominent in educational circles and chairman of the Joint Committee on Health Problems in Education of the National Council of the National Educational Association and the A. M. A.

Dr. Frederick R. Green, Chicago, Ill., Secretary of the Council on Health and Public Instruction of the American Medical Association.

W. S. Rankin, M.D., Raleign, N. C., State Health Officer of North Carolina, Member Executive Committee American Public Health Association.

Arthur L. Day, Ph.D and Sc.D. Director in charge of Geophysical Laboratories Carnegie Institute, Washington, D. C.